I do not agree with having a profession of anesthesiologist assistants. I practiced as a pharmacist for 44 years in hospitals, independent and chain pharmacies so I am very familiar with the medical field. I think this is a bad idea.

Patricia Chan

I am opposed to the creation of the Anesthesiologist Assistant. Anesthesiologists are physicians. We already have a license for Physician's Assistant. We should be addressing this through that current licence.

Corbin Moberg, MSPAS

CEO, Omni Staffing Services, Inc

I heard of a potential workforce issue in anesthesia provision in Washington state. I am currently a second year SRNA and plan to return to WA (my home state) once I have graduated. I love my profession, I love the pacific northwest, and look forward to helping to alleviate the shortage of anesthesia providers in the state.

If you have any questions please do not hesitate to reach out to me.

Alana Bayer

This profession would be completely redundant considering CRNA's do the same work. Adding this profession serves no purpose other than to discredit or get rid of CRNAs. I see only negatives to adding an Anesthesiologist Assistant. CRNAs have an already thriving profession with appropriate school and licensure in place.

Thank you for taking comments from the public.

Victoria Vizcarra, RDH

I work in health care and think creating this position for an Anesthesiology assistant is a great idea. I look forward to hearing from you with more details.

Collette Riopelle

There should be a bridge program for Anesthesia Technologist or Technicians.

Daisy Roy

Interesting that the third criterion was decided as "not applicable". The DOH will have to defend this in the future when we demonstrate increasing costs to the public.

The public could be effectively protected by "other, more cost-beneficial means", meaning, the option to *not allow* anesthesiologist assistants to practice in Washington. By allowing licensure for AA's to practice in Washington, you will be increasing the costs to the Washington tax paying public, both by adminstrative costs of regulating an entirely new profession at DOH, and increased costs of hospital and procedural care to patients.

Here, the public could be protected by "other, more cost-beneficial means", by denying licensure of a profession that will inevitably increase anesthesia costs to patients, and bureaucratic costs to taxpayers in general. I don't know what the cost increase will be to regulate a new profession, but many tax payers are fed up with increasing bureaucratic costs in WA.

I previously asked to consider the math when analyzing costs to patients. Both: 1/4 anesthesiologist (300k/year)+ 1 anesthesiologist assistant(170k/year), 24 hours a day 7 days a week. Or (chose one) anesthesiologist(300k/year) -or- CRNA (190k/year) 24/7. Obviously, the public CAN be protected by more cost-beneficial means by not trying to fix something that was not broken to begin with. The only thing WSSA will tell you that is broken are their attempts to control anesthesia by refusing to hire CRNAs.

Also, when reviewing the patient safety language:

"Clarify the definition of supervision to require the supervising anesthesiologist to be present in the operating suite, office, obstetrical unit, or other setting; and present in the operating room during induction of general or regional anesthesia or emergence from general anesthesia."

Hal Olyskier

As an anesthesiologist and Washington State citizen, I am writing to thank you for your draft Report to the Legislature finding in favor of the proposal to license certified anesthesiologist assistants (CAAs) in our state and to urge you to continue this favorable support in your final report. Currently, anesthesiologists have only one option for a non-physician anesthesia provider – authorizing CAAs to practice here would expand that option to include an additional provider. Moreover, it would bring additional qualified mid-level providers to our state, and importantly, would provide our patients with access to the benefits CAAs already provide to nearly 20 other jurisdictions. CAAs are highly trained master's degree level non-physician anesthesia care providers. They work under the medical direction of anesthesiologists to implement anesthesia care plans. CAAs work exclusively within the Anesthesia Care Team environment as described by ASA. The Anesthesia Care Team consists of a supervising anesthesiologist and from 1 to 4 non-physician anesthesia providers (i.e., CAAs, nurse anesthetists, or anesthesiology physician residents/fellows). All CAAs possess a premedical undergraduate background and complete a comprehensive didactic and clinical program at the graduate school master's degree level. They are trained extensively in the delivery and maintenance of quality anesthesia care as well as advanced patient monitoring techniques. Hospitals and related institutions seeking to utilize the Anesthesia Care Team approach to patient care should be authorized to do so with any qualified anesthesia provider under physician-led care and NOT be deprived the choice of qualified, medically-based trained CAAs. CAAs undergo rigorous and advanced graduate education in accredited master's degree programs ranging from 24 to 28 months, focusing on the Anesthesia Care Team approach to anesthesia practice. As a pre-requisite for admissions, applicants must hold a bachelor's degree, complete the same pre-medical course work that physicians complete, and score competitively in upper

percentiles on the MCAT (Medical College Admission Test). CAAs are as safe and effective as nurse anesthetists and there is peer-reviewed, credible evidence to support this position. A 2018 study published in the peer-reviewed journal Anesthesiology confirmed the safety and efficacy of CAAs when it examined care between an anesthesiologist – nurse anesthetist team and an anesthesiologist – anesthesiologist assistant team. The results found "the specific composition of the anesthesia care team was not associated with any significant differences in mortality, length of stay, or inpatient spending." My anesthesiologist colleagues who work with both CAAs and nurse anesthetists can attest to the complete interchangeability of the two types of non-physician anesthesia providers. CAAs and nurse anesthetists have identical patient care responsibilities and technical capabilities – a view in harmony with their equivalent treatment under the Medicare Program. I want to thank you for your initial draft finding in favor of licensing CAAs in Washington State and strongly urge you to continue to support this position as you draft the final report, for the reasons highlighted above. Thank you for your consideration.

Dr. Jeremy L. Hansen

Hello, I will share my experience working with AAs in Missouri. I have found the majority of AAs lack the knowledge and experience to provide safe anesthesia. They are 100% reliant on the anesthesiologists for every anesthetic given and are unsafe in emergency situations. Every anesthetic I give is different and requires fast retrieval of my knowledge and skillset to actively adjust to the patient's needs. AAs do not have the adequate training to do this well. I have spent years as an RN, gaining experience before I even entered Anesthesia school. Our training is intensive in all disciplines of anesthesia, pharmacology, physiology, chemistry, physics and research. This is a power grab by anesthesiologists to remain relevant in our current healthcare system. Anesthesiologists are high costs to hospitals and research shows they do not give better or safer anesthesia compared to CRNAs. We have been proven over and over to give cost efficient and very safe anesthesia. Our patient care is renowned.

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I am extremely disappointed that the Department of Health is recommending anesthesiologist assistant licensure in its draft sunrise report. The public will not be protected by licensing anesthesiologist assistants (AAs). I urge you to change your recommendation and reject licensure of AAs.

The administration of anesthesia, including general anesthesia, has inherent risks to patients. These risks include pain, nausea and vomiting, laryngeal damage, anaphylaxis to anesthetic agents, cardiovascular collapse, respiratory depression, and dizziness. We must ensure that all anesthesia providers are safe to practice and are equipped with the skills to respond to medical emergencies.

The administration of anesthesia is safe because of the skillset and training of the provider, their ability to immediately intervene to maintain patient stability, and continuously evaluate the interventions to maintain patient safety. A "simple anesthetic" does not exist. AA education and training does not ensure the critical thinking skills necessary to respond to immediate patient emergencies. For example, there is no requirement for AAs to have any patient care experience prior to beginning their training. AAs do not have a broad foundation to reference when a patient's condition deteriorates. When life and death decisions are required, the operating surgeon will be forced to step in until the anesthesiologist, who is caring for other patients under anesthesia throughout a hospital, becomes available. This situation places the patient at immense risk at their most vulnerable of moments.

Results will negatively impact the patient, provider, surgeon, and hospital. Citizens of Washington State deserve proven, safe providers. The quality of care that AAs provide remains unknown; no meaningful

research data exists concerning AA anesthesia quality and safety. The anesthesia care team model, which their supervision is mandated, is inefficient, costly, and concerning their lack of experience, would leave patients vulnerable.

In contrast, the excellent, safe anesthesia care that CRNAs offer with associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals. Washington state must support its existing, high quality anesthesia providers, CRNAs and physician anesthesiologists. Licensure for a narrowly trained provider with limited usefulness will not be beneficial in many healthcare settings, especially during our current COVID crisis. CRNAs are prepared to be instrumental in providing access to quality care while decreasing healthcare costs. Please reject licensure for anesthesiologist assistants.

T. Bee

Let it be perfectly clear to the members of the department of health who are tasked with assessing the need for Anesthesiologist Assistants (AAs) in Washington State that this effort by the Washington State Society of Anesthesiology (WSSA) has nothing to do with need or patient safety. The campaign is strictly an attempt to maintain the status quo of power, control and finances by the WSSA. The use of AAs in a clinical environment increases cost and reduces efficiency in a simultaneous manner without a single shred of evidence that patient safety is improved.

Thank you for considering my opinion.

Raymond O'Keefe, CRNA (23 years)

I currently practice as a CRNA in the great state of Washington. I was surprised to learn the Department of Health is considering Anesthesiologist Assistants (AA's) in our home state. I feel the draft does a great job outlining many of the shortfalls of AA's education along with the associated increased cost of anesthesia related services. I would urge you to look into alternatives for increased patient access and reduced cost for anesthesia services before passing this current legislation.

The Anesthesiologist Assistant education and practice is riddled with short coming and limitations to clinical practice. To begin, a strong clinical background, or experience working in healthcare is not a prerequisite for AA education. Prior to doctorate training as a CRNA, it is required you are competent and experienced in the Intensive Care Unit. Currently, a graduating CRNA has 4 years of undergraduate and 4 years of postgraduate anesthesia training, along with at least 2 years of work in the intensive care. These 10 years of education and clinical hours are equal to the physician level of training. AA's are condensing their anesthesia training into 24-28 months which is severely inferior to all other anesthesia providers.

The discussion about cost and access to affordable anesthesia services favors the CRNA profession significantly. The AA cannot practice rurally and less than 20% of physician anesthesiologist work in rural hospitals. Many rural hospitals only need 1 anesthesia provider at a time. This role is perfect for the CRNA, not the AA/physician care team model.

If the DOH decides to move forward with this legislation I highly recommend you consider the following:

1. Medical direction should be clearly identified and include a 1:2 ratio of physician to AA to ensure proper accessibility during an emergency. Since the AA is unable to administer medications

without direction, nor are they trained to, the physician should be readily available to resume care of a patient immediately in the operating room. The physician should also be required to round on every patient hourly receiving an anesthetic, which includes intrathecal, epidural and regional anesthetics. The physician should also be in house while any and all these anesthetics are being administered or monitored.

2. Continuing education and certification should include hours similar to other anesthesia providers.
3. The AA cannot administer medications or respond to an emergency without a physician physically present within the hospital and prior evaluation of the patient before proceeding.

In conclusion, I do not think AA's are the solution to the current healthcare climate in Washington. AA's have an extremely limited practice and provide limited resources within a community or hospital. Please understand that the AA/physician model is must more expensive than an independent CRNA model. Also, the CRNA versatility and training is being further utilized during the current Covid-19 crisis by taking their expertise to the emergency rooms and ICU's of hospitals. CRNA's around the country have stepped up to help shoulder the burden of the pandemic and shift care where it is needed most. Washington should focus on enhancing training for physician anesthesiologist and CRNA's rather than letting a loophole profession practice anesthesia in our state.

Thank you for your time

Alex Pentecost

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I am extremely disappointed that the Department of Health is recommending anesthesiologist assistant licensure in its draft sunrise report. The public will not be protected by licensing anesthesiologist assistants (AAs). I urge you to change your recommendation and reject licensure of AAs.

The administration of anesthesia, including general anesthesia, has inherent risks to patients. These risks include pain, nausea and vomiting, laryngeal damage, anaphylaxis to anesthetic agents, cardiovascular collapse, respiratory depression, and dizziness. We must ensure that all anesthesia providers are safe to practice and are equipped with the skills to respond to medical emergencies. The administration of anesthesia is safe because of the skillset and training of the provider, their ability to immediately intervene to maintain patient stability, and continuously evaluate the interventions to maintain patient safety. A "simple anesthetic" does not exist.

AA education and training does not ensure the critical thinking skills necessary to respond to immediate patient emergencies. For example, there is no requirement for AAs to have any patient care experience prior to beginning their training. AAs do not have a broad foundation to reference when a patient's condition deteriorates. When life and death decisions are required, the operating surgeon will be forced to step in until the anesthesiologist, who is caring for other patients under anesthesia throughout a hospital, becomes available. This situation places the patient at immense risk at their most vulnerable of moments. Results will negatively impact the patient, provider, surgeon, and hospital.

Citizens of Washington State deserve proven, safe providers. The quality of care that AAs provide remains unknown; no meaningful research data exists concerning AA anesthesia quality and safety. The anesthesia care team model, which their supervision is mandated, is inefficient, costly, and concerning their lack of experience, would leave patients vulnerable. In contrast, the excellent, safe anesthesia care

that CRNAs offer with associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.

Washington state must support its existing, high quality anesthesia providers, CRNAs and physician anesthesiologists. Licensure for a narrowly trained provider with limited usefulness will not be beneficial in many healthcare settings, especially during our current COVID crisis. CRNAs are prepared to be instrumental in providing access to quality care while decreasing healthcare costs. Please reject licensure for anesthesiologist assistants.

Dominique Irigoin, CRNA

I cannot express my concern and genuine shock at the prospects of Anesthesiologist Assistants being certified in WA state. I can only ask one question: who would it benefit?

This is a profession that was invented in the late 1950's, directly to combat the presence of CRNA's. It should be noted that it has taken over one half of a century for this group of professionals to gain acceptance in less that half of the states in our nation, and for good reason.

It certainly won't benefit patients. Anesthesia is not a career to be learned in a 2-3 year post graduate course. These individuals often come in with zero medical experience or knowledge. ICU nurses have undergone 4 years of nursing school for their BSN, then additionally had a minimum of 2 years ICU experience. This instills a solid foundation of pathophysiology, pharmacology, and health care in general plus all the necessary patient care fundamentals to help prepare for anesthesia training. These folks have slim to none. Do you really want an individual with a business degree and a 2 year crash course in anesthesia placing your breathing tube for your procedure? Or accessing your central nervous system with an epidural catheter?

It won't benefit WA state. This is a lush, wild state with many rural areas that are not easily accessible by metro areas. These are also areas that are often impoverished, and health care systems feel that financial vice. CRNA's have a demonstrated track record over 1 century old and can provide equivalent, safe anesthesia care at a 50% or greater savings compared to an MD to an already strained system. AA's must work under an MD at a ratio of up to 1:4, which still doesn't come close in reference to quality or fiscal responsibility that a solo CRNA or MD model provides.

It won't benefit current anesthesia providers that reside in WA state. Is there a deficit here? Looking upon Gasworks and Indeed, there are positions available but not in a massive abundance. Additionally, with being in close proximity to nursing unions in CA and OR, pay is usually at or above national average, leading to anesthesia staff retention being more the norm here.

In short, I just have to question the motives here, which I suspect are politically based from our MD counterparts. While I'm all for free market competition, passing AA licensure in our state really makes no sense from a financial standpoint, or in regards to patient safety which is the ultimate priority.

I humbly request you folks to rescind your decision in regards to AA licensure in WA state.

Jesse Broome, CRNA

After reading the draft, I was struck by the limited nature of healthcare education for this proposed new healthcare profession. There does not seem to be a proper healthcare framework for Anesthesiology Assistant education. CRNA's have a nursing school background with broad healthcare education and

experience, and additional training beyond that. Physicians have medical school. It seems as if Anesthesiology Assistant education involves basically learning technical details without a broader context. It seems to make more sense to recruit CRNA's to Washington state to fill open positions, since they are able to function independently and would truly be able to increase the number of anesthesia providers in our state.

Wendy Krauss, RN

While it is no surprise this proposal was recommended out of committee for approval as the support from the Washignton State Society of Anesthesiologist expects high regard. However, the noted justifications for approval are grossly out of line with the desired outcomes and will negatively impact the number of anesthesia providers in the state of Washington, the cost of care and patient access to care.

Specifically, the claim that a 24-28 month education program is adequate, this is out of line for both the claim for expertise by Physician Anesthesiologists (MDA) and the trend for Certified Nurese Anesthesiologists (CRNA). Each of which require no less than 36months of anesthesia specific didactic and clinical training with many providers pursuing further specialization through fellowships. Whats more, both of these groups are required to complete multiple years of clinical and didactic education and training before beginning their respective graduate education (a CRNA must have a bachelors in nursing and be a practicing ICU nurse for no less than one year and an MDA must complete medical school). The claim of safe anesthesia services with such little training is boldly contradictory to both MDA training and CRNA training as well as the standards set by both regulating bodies.

To the claim of financial feasiblity for these providers, it is completely irrational to assume the overall cost and access to care would be better or even equal to what it is today. The math is simple, 4 Anesthesiologist Assists (AA) will be overseen by 1 MDA and then the MDA cannot personally provide direct patient care themselves. While 4 CRNA's require NO MDA and the MDA CAN personally provide direct patient care. In other words, the AA model requires 1 non-productive provider for every 4 productive providers while the salary for this non-productive provider is commonly noted as among the highest salaries in healthcare. If patients are to bear the burden of the AA model, they may completely forgoe surgical services or they may not pay for the services recieved. Neither of these outcomes indicates a financially effective model. More nuanced, the costs for these higher anesthesia teams in critical accsss hospitals with low budgets may lead to surgical survices simply shutting down and reducing the access to care. Both of these situations are currently being mitigated as CRNA's independently provide anesthesia serivices in most rural, ciritcal access hospitals both in the state of Washington and across the country. This model proves every day the financial solvency of our current system and contradicts the AA model being introduced.

I propose a different model all together: Completely disolve MDA's statewide and allow CRNA's to independently provide anesthesia care to all Washingtonians. This is proven to be a safe effective care model in all clinical settings and will undoubtedly reduce overall costs as CRNA salaries are approximately half that of MDA's statewide.

Thank you for your time and consideration.

Paul Brangers

CRNA, DNP

Yakima Valley Memorial Hospital

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA) since 2010, I am disappointed that the Department of Health is recommending anesthesiologist assistant licensure in its draft sunrise report. As a state agency that is suppose to be looking out for the wellbeing of WA state citizens, this recommendation does the opposite.

The public will not be served by licensing anesthesiologist assistants (AAs). I strongly urge you to change your recommendation and reject licensure of AAs. The administration of anesthesia, including general anesthesia, has inherent risks to patients. These risks include pain, nausea and vomiting, laryngeal damage, anaphylaxis to anesthetic agents, cardiovascular collapse, respiratory depression, and death. We must ensure that all anesthesia providers (CRNA and physician anesthesiologists) are safe to practice and are equipped with the skills and knowledge to respond to medical emergencies. The administration of anesthesia is safe because of the skillset and training of the provider, their ability to immediately intervene to maintain patient stability, and continuously evaluate the interventions to maintain patient safety. A "simple anesthetic" does not exist. Truth be told, even in ACT model of anesthesia delivery, in an emergency, a directing physician anesthesiologist is not always readily available, he/she maybe attending to a different life or death situation in adjacent OR suite (with another AA), especially in the states where ratios of supervision are four (4) AAs to (1) one supervising physician anesthesiologist.

AA education and training does not ensure the critical thinking skills necessary to respond to immediate patient emergencies. For example, there is no requirement for AAs to have any patient care experience prior to beginning their training. To my dismay, some go from being a professional cheerleader to the operating room. I am 100% confident that none of us would want a dancer being in charge of our anesthesia delivery. AAs do not have a broad foundation to reference when a patient's condition deteriorates. When life or death decisions are required, seconds do count and patients are well served when a CRNA or a physician anesthesiologist is present. In situations like that, patients are at immense risk at their most vulnerable of moments. Outcomes will negatively impact the patient, surgeon, and hospital.

Citizens of Washington State deserve proven and safe providers. The quality of care that AAs provide remains unknown; no meaningful research data exists concerning AA anesthesia quality and safety. The anesthesia care team model, in which AA supervision is mandated, is inefficient, costly, and concerning their lack of expertise, would leave patients vulnerable. In contrast, the excellent, safe anesthesia care that CRNAs offer with associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.

Washington state must support its existing, high quality anesthesia providers, CRNAs and physician anesthesiologists. Licensure for a narrowly trained provider with limited usefulness will not be beneficial in any healthcare setting, especially during the current COVID crisis. CRNAs are prepared to be instrumental in providing access to quality care while decreasing healthcare costs. I urge you to reject licensure for (AAs) anesthesiologist assistants.

Mikhail Nekhamis, MS, CRNA, ARNP

As a CRNA, I am disappointed in the Department of Health's (DOH) preliminary decision to approve the licensure of anesthesiologist assistants (AAs). I urge you to reconsider this decision and reject this sunrise review application. This is not about anesthesia and providing care, it is about money and

power. Allowing a new licensure for AA's fosters an anti-competitive marketplace between two established, competing service providers. Allowing one provider access to cheaper labor while denying the same market opportunity to the other, will give an unfair advantage to the MD's. Either allow fair market opportunities for both, or deny the new licensure.
Regards,
Christian Schmalz, CRNA, MBA

I am a practicing certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA). I want to express my extreme disappointed that the Department of Health is recommending anesthesiologist assistant (AAs) licensure in its draft sunrise report. This decision will not increase access to care for the citizens of Washington state. It is unfortunate that the multiple descents that have been sent to the DOH, have gone unheard. For over 100 years, both physician and nurse anesthesia providers have been providing safe and effective care to Washington citizens. Adding a provider that lacks the experience for physicians and nurses, will only increase the costs of anesthesia care, not improve access to care

The AA profession was originally added by physician anesthesiologists (MDAs) to take back control from CRNAs. Because both MDAs and CRNAs can practice independently, our physician colleagues preferred a profession that they could control and make money off. An AA must be always supervised, preventing MDAs from responding to operating room emergencies in multiple rooms. Since a CRNA is an independent provider, if an emergency arises, they are trained and able to respond quickly and independently. The administration of anesthesia, including general anesthesia, has inherent risks to patients. These risks include pain, nausea and vomiting, laryngeal damage, anaphylaxis to anesthetic agents, cardiovascular collapse, respiratory depression, and dizziness. We must ensure that all anesthesia providers are safe to practice and are equipped with the skills to respond to medical emergencies.

While it may appear that CRNA and AA training is similar, I can tell you as a CRNA and CRNA educator that they are not. Because CRNAs are critical care nurses prior to starting their training, they have already experience in responding to critical patient emergencies. The years of experience as a critical care nurse cannot be taught via simulation in an AA program. While AA students are learning about advanced critical responses in their training, CRNA students have experienced and executed these protocols multiple times. This allows the CRNA student to spend more time in the operating room providing anesthesia. During their training, CRNA students are allowed to be alone in a room providing anesthesia with available support. An AA student can not do this, and thus lose a lot of the independent experience necessary to be a full-practice provider.

The education that CRNA students receive exceeds the training that AA students receive. Our students are spending less time playing "catch up" that AA students are doing due to their lack of healthcare experience, and they are spending more time in the OR. The CRNA students build on their nursing training by starting advanced education in physiology, pathophysiology, and pharmacology. They also start their training with certification in advanced critical care, advanced cardiovascular life support and pediatric advanced life support. While AA students are needing to spend time in training to learn these things, our students again can spend more time in the OR taking care of patients.

The document provided by the anesthesiologists in their request to bring AAs to WA also mentioned that AAs may practice in the Veterans Administration (VA) system. While this is may be true, at this time, no VA has employed an AA because they are not able to work independently. The two VAs in WA have multiple CRNAs working for them and they work independently or in a supervised practice, but without medical direction. This allows for a decreased need for excess provider, unnecessarily monitoring CRNAs in practice. This is better for our veterans and for the cost of the healthcare

provided. An AA would not be introduced into these practices, because they cannot work without medical direction.

The AA profession will not increase access to care. They will need to be medically always directed. This requires an MDA to be present for all critical portions of a case. We already know that MDAs struggle to meet direction requirements in anesthesia care team environments (ACTs). Their own study Epstein RH, Dexter F: *Influence of supervision ratios by anesthesiologists on first-case starts and critical portions of anesthetics*. ANESTHESIOLOGY 2012; 116:683–91 demonstrated that they are >70% likely to fail to meet direction requirement in a direction practice of 1:4. When there is a CRNA in a room, and a crisis arises, they can act independently and fix the problem. They have the experience and training to meet all the patients' needs on their own. When this happens with an AA, they need an MDA to assist them, and the MDA may not be there if they are already assisting another AA. In a rural hospital, there would likely only be one MDA to assist, resulting in more risk to patients. It just doesn't make sense to have a provider that can't work independently in these situations. And it doesn't make financial sense, to have a provider (MDA) not giving anesthesia and increasing the cost to the system.

I implore you to reconsider bringing a provider into our state that will only increase healthcare cost and waste. This will not increase access to care and will put a major financial strain on a system that is already at risk of falling apart due to the COVID crisis. Both MDAs and CRNAs have stepped up to meet the needs of our state in ways that an AA could not. They are working in intensive care units and emergency rooms, caring for COVID patients while ORs are closed. In this situation, an AA would just be a burden to the system and unable to deploy to these other areas to care for patients.

Washington state must support its existing, high quality anesthesia providers, CRNAs and physician anesthesiologists. Licensure for a narrowly trained provider with limited usefulness will not be beneficial in many healthcare settings, especially during our current COVID crisis. CRNAs are prepared to be instrumental in providing access to quality care while decreasing healthcare costs. Please reject licensure for anesthesiologist assistants.

Sincerely,

Braden Hemingway, DNAP, CRNA, ARNP

I am a certified registered nurse anesthetist (CRNA) who is very disappointed in the Department of Health's recommendation in favor of licensing anesthesiologist assistants (AAs) in Washington. AAs cannot practice independently so cannot improve access to care, especially in rural parts of the state. They can only practice in an Anesthesia Care Team model, which is costly because two providers are paid to do the work of one provider. Since they must work under the direct supervision of an anesthesiologist, AAs are not trained to provide anesthesia independently or handle emergencies. Additionally, there are no meaningful studies showing their safety.

I strongly encourage you to reconsider your recommendation by rejecting AA licensure.

Anonymous

I am a retired US Military veteran, having served a career in the defense of this country. When I was active duty, I had to be hospitalized for surgery on a couple of occasions. Each time, the Anesthesia I was administered, both times, by a Nurse who specialized in anesthesia (Nurse Anesthetist). I was taken very well care of in this regard, as I always thought that a MD had to be the administrator of those services. So I looked into their role and training after I got released from medical care.

I since have learned that the MD's and Nurses who specialize in anesthesia go to the same training, sitting often side by side. I am not a health care provider, but I am a health care consumer. I rely on DOH to ensure that any health care provider that is trained, certified, and licensed is safe to practice. I obviously do not have the tools to do this myself, especially for such a specialized practice as anesthesia. MD's have their med school training and residency behind them before Anesthesia training; Nurses have one, two, or more Masters degrees after their Bachelors in Nursing, and nowadays, Nurses wanting to specialize in anesthesia have their own Ph.D. educational requirements. VERY ADVANCED DEGREES in both cases.

DOH has determined that MD Anesthesiologists and Certified Registered Nurse Anesthetists (CRNAs), now termed Nurse Anesthesiologists, have rigorous education and training requirements and have an incredible amount of evidence to support their safety as a health care provider. I researched this carefully — it is that difficult of a medical procedure to administer.

SO, we have Ph.D. medical degree professionals and Ph.D. nursing degree professionals to administer anesthesia. THIS IS HARDLY a role for assistants, who do not require even a basic 4 year degree to practice!!!

However, for anesthesiologist assistants, in your report, DOH has not shown near enough evidence to conclude that AAs are safe to practice. The DOH sunrise report cites only the lack of disciplinary cases in other states as the sole reason AAs are safe. That's not enough for me. Until there is clear evidence that AAs are safe, DOH should reject AA licensure. And for goodness sakes, are you going to trust your breathing in surgery to someone that doesn't even have a degree in this specialized field…. That's like asking the dentist receptionist to fill your cavity because she or he has billed for it in many months… no thanks. Quit being so taken by the MD Supervision as reason enough for Anesthesia Assistants… if you look closer at this issue, you will find MD Anesthesiologists want to be able to roam room to room in surgery, "closely" supervising the AA's… put yourself on the table Ms. Thomas…the AA push by the MD Anesthesiologists is a financial gain for them, at the sacrifice of the patient safety. Nurse Anesthesiologists stay with each case until that case is over. NO THANKS TO AA's. Wake up and smell the roses Ms. Thomas. AA's are not good for patient safety. AA's are good to the pocket book of MD Anesthesiologists who get to bill for multiple cases at the same time even though they are not in the room for the entire surgery. Don't believe me? Ask those tough questions. This AA thing is politically and financially driven by the MD Anesthesiologists.

It is not in the best interest of patient safety. Me, I want an Anesthesiologists (Nurse or MD) that is going to stay with me the entire time I am in surgery. Wouldn't you?

David L. Palenshus

LCDR, SC, USN (Retired)

As a hospital administrator, I am disappointed in the Department of Health's (DOH) preliminary decision to approve the licensure of anesthesiologist assistants (AAs). I urge you to reconsider this decision and reject this sunrise review application.
The DOH draft report concludes that AA practice is safe, based on the lack of disciplinary cases in the states that credential AAs. However, this is only one measure of safety. As a hospital administrator, I must also consider the delay in care to the patients that seek treatment. These delays are related to inefficiency of care delivery at best. At worst, the delay in care during emergencies can cost lives.
For surgeries and procedures in my hospital that require anesthesia, I must ensure that the anesthesia provider, whether it is a physician anesthesiologist or a Certified Registered Nurse Anesthetist (CRNA), is providing safe, appropriate care. Because they practice independently, they give their full attention to

the patient throughout the surgical procedure. Interventions that are needed to maintain patient stability are immediate.
However, adding an AA to the mix has the potential to delay those procedures, thus delaying care to the patient. An anesthesiologist supervising an AA must maintain medical direction so that the anesthesiologist is able to participate in the most critical portions of the anesthesia care plan. Studies have shown that when an anesthesiologist is supervising two AAs, the anesthesiologist is not able to maintain this medical direction in one-third of all cases. When supervising three AAs, this medical direction is very rarely achieved, only 1% of the time. As a result, surgical procedures are delayed and the patient suffers.
I urge you to protect the public by rejecting the licensure of anesthesiologist assistants. There is simply insufficient data to confirm that their practice is safe for Washington patients.

Sincerely,

Christina Lawrence
DNP

My name is Heather Morris and I am a CRNA. I have worked in healthcare for 17 years and have been a nurse for 13 and CRNA for 9 years. I have an undergraduate degree and masters degree in nursing. I have worked in Washington state and Oregon at a large trauma center, small community hospital, and outpatient surgery center. My years of patient care and education prepared me for this specialized independent work.

I am very concerned about the introduction of AAs to Washington. AAs are a new position and a creation of physician anesthesiologists in order to make more money and monopolize anesthesia contracts in certain areas. AAs are not only completely unprepared for patient care and critical situations, but they are simply a political tool to make more money for supervising physician anesthesiologists. This model is dangerous. AAs are technicians and not independent providers. They will be supervised several at a time. Were there to be more than one need at a time, the AA and patient would be alone. This will result in patient injury, mistakes and death.
Anesthesia is a very nuanced and specialized type of patient care and Washington deserves better. Please reject this attempted money grab and risk to patient care.

Sincerely
Heather Morris CRNA

I am a Certified Registered Nurse Anesthetist(CRNA) in the state of Washington and I vehemently oppose the use of Anesthesiology Assistants(AA) as promoted by the WA DOH Sunrise Report. As a clinical provider with over 25 years of experience, I can tell you the residents of Washington state will be safer **WITHOUT AAs** in it.

Anesthesia is a clinical specialty that takes at least 7 didactic years to train for. Anesthesiology Assistants get 2 years of training for anesthesia. They have no medical background when entering their programs. There is no way they are comparable to CRNAs, yet they will sometimes work in the same role as us. Their lack of medical experience and minimal training will put our patients at risk. The field of AAs is relatively new and there is no research showing they are safe. In contrast, research shows that CRNAs are efficient, high quality providers. Washington State does not need a 3rd anesthesia provider who is **under trained** and probably **unsafe**.

Do not elect to have AAs licensed in our state. For your family's future, the right thing to do is reject the Sunrise Report.

Thank you,

Kathy Poole, CRNA

As an independently practicing CRNA in the state of Washington, I urge you to **reject** the licensure of anesthesiologist assistants. Adding an anesthesia provider (that requires supervision) will not increase access to anesthesia providers.

Thank you,

Nicole Liebertz, CRNA

I have first hand experience of Anesthesiologist Assistants working in Texas and have seen how dangerous they have been in the hospital setting. To provide real life situations of what occurs "behind the doors," let me enlighten you. Anesthesiology Assistants are used as a political and money making tool by the physician anesthesiologists that advocate for them. They are able to be billed in a 4:1 ratio of assistants to physicians, providing the most amount of income to the physician who is "watching" them, that is really the only true benefit of having AAs for the physicians who advocate for them. Many times I have heard the anesthesiologists call AAs behind doors their "stool monkeys" or "button pushers" because they too don't trust their own "assistant" colleagues with the anesthesia being given.

I will tell you that every surgeon, CRNA, and physician anesthesiologists I have spoken to would never allow themselves or their loved ones to be under the care of an Anesthesiologist Assistant. I have had surgeons specifically request that no surgeries are to be performed by an AA due to the poor patient outcomes and lack of knowledge required for the care of their patients. This is the truth. However, the patients that suffer this lack of knowledge are the general public who are unaware. Just look at who gave Jerome Adams, physician Anesthesiologist and former US Surgeon General, his anesthesia? Of all the options, he chose the best for his care, which was a CRNA.

Unfortunately, money speaks louder than words, so as long as insurance will pay for this medical direction model for AA's, physician anesthesiologists will lead in the compensation field of anesthesia without actually providing any anesthesia. This is such an issue with states using AAs that many anesthesiologists who work in these merical direction settings make more money than many of the surgeons in the same hospital. If the physician's provided direct anesthesia care in all healthcare settings in the state of Washington (and the United States for that matter), there would be no shortage of anesthesia providers, only a shortage of extremely high and over inflated salaries.

Please consider that making the decision to have Anesthesiology Assistants only renders for more expensive and divided anesthesia care that will only become more political and expensive for Washington state and its citizens. There is a reason AAs are only legal in 28% of the country, and yet they have been around since 1969. Many states will not tolerate risking the lives of their loved ones or their citizens utilizing underprepared providers. CRNAs have been around since the 1800's, fully licensed and legal to practice in all 50 states and are able to practice independently in almost every state, including Washington state.

I also want to point out that although AA's are allowed to practice in the VA system, I have never heard of an AA actually working in the VA. This is because the VA does not recognize this profession as an anesthesia provider like the CRNA or physician anesthesiologist and they are classified instead as "physician assistants" with substantially lower salaries than other true anesthesia providers. This comes

to show you that even the VA does not recognize the AA's as competent anesthesia providers to fulfill the anesthesia provider shortage.

Sincerely,

Michael Mielniczek, CRNA

As a retired military CRNA, with research, combat and teaching experience, and a member of the Washington Association of Nurse Anesthetists, I encourage you to reject the sunrise review application regarding licensure for anesthesiologist assistants (AA). Basically approving physician assistants to do anesthesia will NOT improve access to care in our state as they must be supervised by the anesthesiologist. Obviously, since you will be paying for 2 providers for one service it will restrict acces and drive up costs. Healthcare dollars are scarse. So, if AA cannot practice without a licensed anesthesiologist where is the value added perspective as there is NO peer reviewed studies that prove the safety of AAs.

As you know Certifiied Registered Nurse Anesthetists (CRNAs) are independently licensed to practice in all 50 states. CRNAs provide the bulk of anesthesia services (72%) in WA rural hospitals. Approving AAs to perform anesthesia services will not increase anesthesia services and will only add costs. CRNAs are actually the safest, most cost effective method for anesthesia services. . It makes no sense to authorize AAs, a less qualified anesthesia provider that can only work with anesthesiologists and can't be used in any area where anesthesiologists don't practice, such as many rural locations. Please reject the application for licensure of anesthesiologist assistants.

Thank you for your time with this important issue.

Sincerely,

Joseph O'Sullivan, (LTC, ret), CRNA, PhD

I recently learned about the Department of Health's (DOH) preliminary decision to approve the licensure of anesthesiologist assistants (AAs). I'm reaching out to ask you to reconsider the decision and reject their application.

I do not work in the health care sector or have expertise in the field. I am 100% a patient and count on the DOH to keep me safe and ensure health care providers are adequately licensed and capable to perform the work on me as a patient.

The DOH has determined that anesthesiologists and certified registered nurse anesthetists have that level of expertise and training. But there has been little evidence to show that anesthesiologist assistants have the same level of specialized training and education. Anesthesia practice by insufficiently trained individuals is unsafe and irresponsible.

I would not allow myself or my family to be administered an anesthetic by an AA. At least not until the DOH can adequately prove that AA's have gone through the same level of training and licensure as anesthesiologists and CRNA's.

Sincerely,

Sean Howley

The Washington Association of Nurse Anesthetists (WANA), on behalf of its over 900 members, submits the following comments regarding the Department of Health's (Department) draft recommendation to license anesthesiologist assistants (AAs). We are extremely disappointed that the Department is recommending anesthesiologist assistant licensure in its draft sunrise report, despite the lack of studies indicating the safety of AA's administering anesthesia . The public will not be protected by licensing anesthesiologist assistants. We urge you to change your recommendation and reject licensure of AAs. They are not proven as a safe provider of anesthesia.

The Department's rationale for recommending AA licensure rests on the lack of disciplinary data from other states showing that AAs are being disciplined for incidents of harm. However, this cannot, and should not, be the only determining factor when it comes to the important decision as to whether to license a new profession.

As you know, the disciplinary process is based on patient or peer complaints submitted to a state's health department. The complaint process is an arduous one and one that many consumers and health professionals won't participate in. Moreover, as a professional that must be supervised by an anesthesiologist, it is unclear whether other states will have stand-alone data on AAs, or whether complaints about AAs will only be reflected in a complaint against an anesthesiologist. Either way, complaint data alone should not be the only factor considered.

As we pointed out in our July 15th comment letter, no peer-reviewed studies in scientific journals have been published regarding the safety and quality of care of AA practice or AA anesthesia outcomes. There is no meaningful research data concerning AA anesthesia safety. In contrast, the excellent, safe anesthesia care that CRNAs provide and associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.

The administration of anesthesia, including general anesthesia, has inherent risks to patients. These risks include pain, nausea and vomiting, laryngeal damage, anaphylaxis to anesthetic agents, cardiovascular collapse, respiratory depression, and dizziness. We must ensure that all anesthesia providers are safe to practice and are equipped with the skills to respond to medical emergencies. The administration of anesthesia is safe because of the skillset and training of the provider, their ability to immediately intervene to maintain patient stability, and continuously evaluate the interventions to maintain patient safety. A "simple anesthetic" does not exist.

AA education and training does not ensure the critical thinking skills necessary to respond to immediate patient emergencies. For example, there is no requirement for AAs to have any patient care experience prior to beginning their training. AAs do not have a broad foundation to reference when a patient's condition deteriorates. When life and death decisions are required, the operating surgeon will be forced to step in until the anesthesiologist, who is caring for other patients under anesthesia throughout a hospital, becomes available. This situation places the patient at immense risk at their most vulnerable of moments. Results will negatively impact the patient, provider, surgeon, and hospital.

Patients in Washington state deserve proven, safe providers. The quality of care that AAs provide remains unknown. Without further data showing that AAs are safe, licensure for AAs should be rejected.

Thank you for the opportunity to provide comments on behalf of WANA.

Ellen Kraus-Schaeffer, RN, ARNP, CRNA

President

As an independent practice CRNA who has worked my entire career in the state of Washington beginning in 2010, I can personally attest to the distasteful, blatantly inaccurate and outright false data my anesthesiologist colleagues continue to perpetuate. To the layman, this propaganda appears legitimate. Please educate yourselves and seek the truth. Understand the politics. This is business. The current nationwide, economic trends are decreasing the job market for anesthesiologists which is a monumental loss for our communities and our healthcare system. The solution is not Anesthesia Assistants. The solution is MDs and CRNAs working independently side by side, complementing each other in our skills and experience. Teamwork saves lives. AAs are nothing more than a move for job security on the part of MDs. If AAs cannot work independently, there will always be a need for a supervising anesthesiologist. It's that simple. Perhaps the real problem in Washington is the cost of living. Positions go unfilled because providers from out of state are reluctant to decrease their standard of living to move to Washington. Perhaps providers are moving out of this job entirely because having to deal with these ugly politics wears on us, adding incredible stress to our already difficult days. Perhaps hospitals simply do not pay enough and job seekers, CRNA and MD alike deserve more. Perhaps the current legal standing of non-compete clauses in provider contracts is adding to the inability of WA providers to seek other job opportunities.

The real economics of this argument seem to be universally ignored in every pro/con argument about AAs. If AAs make less in salary than a CRNA and MD groups can bill for their services and keep more of the revenue, who benefits? Not patients and their families. The money stays with the anesthesiologists. It does nothing to decrease the cost of healthcare. The services are billed the same and paid the same. Do hospitals save money? No, because there will then be a need to hire more MDs to supervise AAs. The intense education, training and invaluable experience of our amazing anesthesiologists in WA state should not be wasted supervising AAs. They should be at the head of the bed, providing anesthesia care. Healthcare is not a highly profitable business as a whole but it would behoove hospitals and surgery centers to support independent CRNA and anesthesiologist providers alike, not muddy the waters with another provider with no proven long term economic benefit.

Please educate yourselves. Take the time to read the research confirming the safety and economic viability of independent CRNA and MD practice. Take the time to understand the politics and the actual reason for the creation of the AA profession. Unfortunately, there are some who are hoping you do not take the time and instead, do not delve deeper than these letters.

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I urge you to reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs). AAs do not improve access to care in

Washington; in fact, there is reason to believe they will result in restricting access and driving up costs. AAs are narrowly trained and cannot practice without a licensed anesthesiologist. Finally, AAs are an unproven provider with no peer-reviewed studies that prove the safety of AAs.

Certified Registered Nurse Anesthetists (CRNAs) are certified anesthesia experts independently licensed to practice in all 50 states and the District of Columbia. Because of their extensive education and training, CRNAs are permitted by federal and state laws and regulations to provide every type of anesthesia service to patients without the involvement or presence of a physician anesthesiologist. All research studies on anesthesia safety and cost-effectiveness conducted in the last 20 years confirm that CRNAs provide the safest, most cost-effective anesthesia care to patients.

In contrast, AAs can only practice in 15 states plus the District of Columbia. They are limited by their training and licensure to providing clinical support to anesthesiologists and may not practice "apart from the supervision of an anesthesiologist," according to the American Academy of Anesthesiologist Assistants (AAAA). Because AAs are required to be directly supervised by an anesthesiologist, the AA/anesthesiologist team is one of the costliest anesthesia delivery models with no scientific evidence of increased patient safety.

Because AAs cannot practice without anesthesiologist supervision, AAs do not practice in rural areas where CRNAs working without anesthesiologist involvement are the primary providers of anesthesia care. In fact, CRNAs are the only anesthesia provider in 72% of Washington's rural hospitals. AAs, in contrast, can only practice where anesthesiologists practice, which greatly limits their utilization. AAs, therefore, can't help solve problems of inadequate access to anesthesia care in rural and underserved communities.

Because CRNAs do not need to practice with an anesthesiologist, they are much more cost effective than AAs. With an AA, the need exists to educate and use two providers – the supervising anesthesiologist and the AA – to provide anesthesia care to one patient. With a CRNA, only that individual is needed to provide total anesthesia care to the patient. Essentially, compared with the anesthesiologist-AA staffing arrangement, one CRNA can provide the care of two providers.

AAs are an unproven provider. No peer-reviewed studies in scientific journals have been published regarding the quality of care of AA practice or AA anesthesia outcomes. The quality of care that AAs provide is unproven, as there is no meaningful research data concerning AA anesthesia safety. In contrast, the excellent, safe anesthesia care CRNAs provide and associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.

Finally, I love my job. Currently, I work with CRNAs and MDs, all independent practice. We have an incredible team I am proud to be a part of every day. This model has proven itself; it works.

Thank you for your time and consideration,

Connie Walton-Hoskinson, CRNA

ARNPs United of Washington State (AUWS) represents the more than 9000 licensed advanced registered nurses (ARNPS) in the state. ARNPs include nurse practitioners, nurse anesthetists, nurse midwives and clinical nurse specialists.

AUWS continues to oppose the creation of a license for anesthesiologist assistants (AAs). The position of AUWS is there is no need for a new profession to address gaps in and improve access to anesthesia care. Nurse anesthetists can fill the gap and improve access to anesthesia care.

Nurse anesthetists are already the providers of most anesthesia care in rural Washington. The applicant group, the Washington State Society of Anesthesiologists, has consistently stymied new nurse anesthetist programs in the state from being developed by creating barriers to clinical placements that are essential to new programs.

Nurse anesthetists are educated and licensed to deliver anesthesia care without physician involvement. It is not efficient or effective to create a new profession that requires physician supervision. The requirement for supervision limits an AA from working when the supervising anesthesiologist is unavailable such as when on vacation, taking sick leave, or attending conferences. Nurse anesthetists have a full scope of practice and can perform all aspects of anesthesia care while in contrast the AAs can only perform technical functions.

Nurse anesthetists have a proven record of delivering anesthesia care to patients undergoing surgery in the hospital and ambulatory setting, including dental and eye procedures, as well as in federal facilities such as military installations, Veteran Affairs facilities and Indian Health Service units. Nurse anesthetists are recognized in all 50 states and have documented high quality outcomes of care published in peer-reviewed articles in highly regarded journals. This is not eh case for AAs. Additionally, the Centers for Medicare and Medicaid Services (CMS) recognizes this difference as it prohibits AAs from billing Medicare for non-medically directed services and AAs must be medically directed for

reimbursement. Nurse anesthetists are authorized to bill Medicare directly for non-medically directed services.

From a workforce perspective, employment of nurse anesthetists is a better investment than employment of an AA. Graduate education for nurse anesthetists provides the health care workforce with a fully autonomous provider who can work in urban, suburban and rural settings without restrictions. Graduate education for an AA results in a health care worker who can be employed only with supervision and with substantial restrictions. Licensure of AAs does not solve the problem of access to anesthesia care.

Investing in the expansion of graduate programs in Washington State for nurse anesthetists will solve the problem of access to anesthesia care.

ARNPs United of Washington

I am writing to state my opposition to allowing AAs to practice in the state of Washington. I have been a practicing CRNA in this state for 23 years. I have worked in numerous settings, including teaching hospitals, community hospitals, and a variety of private practice clinics. Many years of my practice have been as a solo independent anesthesia provider.

My opposition to an AA practice in our state is mainly twofold. First, AAs are not licensed to practice independently in any setting. They must be directly supervised by a physician anesthesiologist. It does not make any kind of sense that two individuals should provide a patient's anesthetic when one will do the job nicely (an anesthesiologist or a CRNA). AAs would not be able to provide any kind of rural services, which require an independently functioning provider capable of doing everything from labor management to emergency airway support in an emergency room. They are extremely limited in their capacity.

Secondly, an anesthesiologist/AA model is far more expensive to the public. In fact, the most cost effective way to provide anesthesia is with a CRNA only model. Numerous studies have shown no difference in patient outcome whether a CRNA or anesthesiologist provides their care. I don't know of any studies supporting a similar outcome regarding the use of AAs.

Thank you for your time.

Sincerely,

Kim Larsen

I am a certified registered nurse anesthetist, in Washington State, and more importantly, in this circumstance, a patient in the healthcare system in Washington state. I urge you to reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs). AAs do not improve access to care in Washington, and they do not have the education or skillset to practice independently. They need constant supervision, which defeats the purpose of having another provider, in the first place. Because AAs are required to be directly supervised by an anesthesiologist, the AA/anesthesiologist team is one of the costliest anesthesia delivery models with no scientific evidence of increased patient safety

I have been in independent practice for 31 years and practicing anesthesia for 39 years. I know the timely decisions that anesthesia care demands. There isn't time to wait for someone else to tell you what to do. Patients deserved properly trained and licensed providers. They choose their surgeon, but

have no idea who will provide their anesthetic until the day of surgery. It is only right that they can know that the person caring for them has proper training.

In the past, there was a PA who was hired by Virginia Mason, to practice as an anesthesia provider. Firstly, that was not legal in Washington state, but it happened. What they found was he did not have the skills to provide anesthesia care and could not be left alone, at all. Also, because he could not be licensed in Washington to practice anesthesia, and that was pointed out to administration, by a CRNA, it should not have happened in the first place. He was asked to leave the department due to lack of skills.

The bottom line is that nurses and physicians have a lot of academic and clinical requirements that AA's do not have. Let's keep patients safe, in Washington State and reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs).

There are solid reasons why AAs can only practice in 15 states plus the District of Columbia. They are limited by their training and licensure to providing clinical support to anesthesiologists and may not practice "apart from the supervision of an anesthesiologist," according to the American Academy of Anesthesiologist Assistants (AAAA). Because AAs are required to be directly supervised by an anesthesiologist, the AA/anesthesiologist team is one of the costliest anesthesia delivery models with no scientific evidence of increased patient safety.

Just like I have no idea what it takes to do your job, I am relatively certain you do not know what it takes to take a patient through an anesthetic and do no harm to them. Leave the care of patients to skilled providers that have proven their skillset and knowledge for over one hundred years. Anesthesia is not where you should ever consider licensing an unprepared provider to care for patients. Please do not pass legislation that puts patient at risk. Would you want an unskilled provider caring for your loved one?

Thank you for your time.

Respectfully,

Bettie Orr CRNA

In regards to the licensure of Anesthesiologist Assistants in Washington State, this would be a step backwards in health care. These practitioners have no experience in Intensive Care Units, in which CRNA's have substantial experience. This is what provides CRNA's with the experience to provide top-notch care, often regarded as superior to anesthesiologists. Patient care is a stake here, as we have been moving forward in the state, given independent status of CRNA's. This would be a step backwards and a blow to patient care. We kindly and firmly ask that you do not allow these lower level providers licensure in Washington State, where health care is renowned for its world-class status. Let's keep health care in Washington State top-notch and exclusive to top-notch providers. Thank you for your time!

Mitchell Keszler, CRNA, MSN

I am a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA). It is disappointing that the Department of Health is recommending anesthesiologist assistant licensure in its draft sunrise report. I urge you to change your recommendation and reject licensure of AAs.

The administration of anesthesia, including general anesthesia, has inherent risks to patients. These risks include pain, nausea and vomiting, laryngeal damage, anaphylaxis to anesthetic agents, cardiovascular collapse, respiratory depression, and dizziness. We must ensure that all anesthesia providers are safe to practice and are extremely prepared to handle medical emergencies. The administration of anesthesia is safe because of the skillset and training of the provider, their ability to immediately intervene to maintain patient stability, and continuously evaluate the interventions to maintain patient safety. AA education and training does not ensure the critical thinking skills necessary to respond to immediate patient emergencies.

Ironically, I was talking with a healthcare provider today who told me that earlier in his career he was approached by an anesthesiologist to become an AA. When he asked why he should become an AA instead of a CRNA, the anesthesiologist told him it was because an AA could get through training quicker and there was an anesthesia personnel shortage. That is a red flag. Less training and no prior patient care experience required means that AAs do not have the foundation necessary to reference when a patient's condition deteriorates.

I work in a critical care hospital that does not have the funds to support the cost of an anesthesiologist or an anesthesia care team model. Therefore, an AA could not practice in my facility. And this legislation does not further the cause to provide rural healthcare to the people of Washington State.

Citizens of Washington State deserve proven, safe providers. The quality of care that AAs provide remains unknown; no meaningful research data exists concerning AA anesthesia quality and safety. The anesthesia care team model, which their supervision is mandated, is inefficient, costly, and concerning their lack of experience, would leave patients vulnerable. In contrast, the excellent, safe anesthesia care that CRNAs offer with associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals. Washington state must support its existing, high quality anesthesia providers, CRNAs and physician anesthesiologists. CRNAs are prepared to be instrumental in providing access to quality care while decreasing healthcare costs. Please reject licensure for anesthesiologist assistants.

Sincerely,

Dustin Billington, CRNA

I work as a Certified Registered Nurse Anesthetist (CRNA) in the state of Washington. I have done so for the last 5 years. I am also a member of the Washington Association of Nurse Anesthetists (WANA). I am taking the time to personally write and urge you to reject the sunrise review application regarding licensure for Anesthesiologist Assistants (AAs). Please take the time to read through the following reasons why I believe AA licensure for this state is illogical, costly and unsafe.

AAs decrease access to care.

Proponents of this licensure argue anesthesia services in Washington need improved access to care. While this may be true, the answer to this dilemma isn't found with AA licensure. In fact, bringing in AAs would further restrict access to care. Let me explain why this is the case.

Certified Registered Nurse Anesthetists (CRNAs) are certified anesthesia experts independently licensed to practice in all 50 states and the District of Columbia. Because of their extensive education and training, CRNAs are permitted by federal and state laws and regulations to provide every type of anesthesia service to patients without the involvement or presence of a physician anesthesiologist. All research studies on anesthesia safety and cost-effectiveness conducted in the last 20 years confirm that CRNAs provide the safest, most cost-effective anesthesia care to patients.

In contrast, AAs can only practice in 15 states plus the District of Columbia. They are limited by their training and licensure to providing clinical support to anesthesiologists and may not practice "apart from the supervision of an anesthesiologist," according to the American Academy of Anesthesiologist Assistants (AAAA). Because AAs are required to be directly supervised by an anesthesiologist, the AA/anesthesiologist team is one of the costliest anesthesia delivery models with no scientific evidence of increased patient safety.

Because AAs cannot practice without anesthesiologist supervision, AAs do not practice in rural areas where CRNAs working without anesthesiologist involvement are the primary providers of anesthesia care. In fact, CRNAs are the only anesthesia provider in 72% of Washington's rural hospitals. AAs, in contrast, can only practice where anesthesiologists practice, which greatly limits their utilization. AAs, therefore, can't help solve problems of inadequate access to anesthesia care in rural and underserved communities.

If for any reason an AA's supervising anesthesiologist is not available, off-site, on vacation, or simply home for the day, the AA may not provide anesthesia care. The AA anesthesiologist- driven mode of practice, therefore, is inflexible and fails to adequately meet the needs of patients, hospitals, ambulatory surgical centers, or other healthcare settings.

While nurse anesthesia educational programs graduate nurse anesthetists prepared for autonomous practice, the AA program curriculum is characterized by training that only allows them to assist anesthesiologists in technical functions.

Because CRNAs do not need to practice with an anesthesiologist, they are much more cost effective than AAs. With an AA, the need exists to educate and use two providers – the supervising anesthesiologist and the AA – to provide anesthesia care to one patient. With a CRNA, only that individual is needed to provide total anesthesia care to the patient. Essentially, compared with the anesthesiologist-AA staffing arrangement, one CRNA can provide the care of two providers.

AAs threaten educational pathways for those providers who serve rural and underserved areas –CRNAs.

Currently, Washington has one educational program, Gonzaga University. Washington also receives students From Oregon Health and Science University in Oregon and Westminster University in Utah. Clinical training is an important part of CRNAs' education. The Council on Accreditation of Nurse Anesthesia Education Programs specifies that only a recognized expert in anesthesiology care (a physician anesthesiologist or CRNA)may be involved in the training of a new CRNA. This has been interpreted to mean that new CRNA residents may not complete their training in operating rooms in which an AA is practicing. In states that have approved AA licensure, CRNA training programs continue to report problems related to AAs and clinical sites that resulted in CRNAs leaving departments and elimination of clinical sites. The 15 states in which AAs are now licensed to practice, CRNA residency slots have been reduced and fewer student nurse anesthetists are in the educational pipeline. CRNAs – but not AAs –can provide anesthesia services to those areas of the state that lack physician anesthesiologists. If the legislature approves AA practice in the state, it will further reduce the number of residency slots for CRNAs and potentially lead to an anesthesia provider shortage in the parts of the states served by CRNAs.

AAs are an unproven provider.

CRNAs were among the first anesthesia providers and have over 100 years of excellent, safe anesthesia care provided. CRNA anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals. In contrast, no peer-reviewed studies in scientific journals have

been published regarding the quality of care of AA practice or AA anesthesia outcomes. The quality of care that AAs provide is unproven, as there is no meaningful research data concerning AA anesthesia safety.

AAs are anticompetitive and increase cost.

There are two reasons why some would favor licensing AAs in this state and neither one benefits the citizens of this state.

First, as we already discussed, AAs have to work under supervision. This ACT (Anesthesia Care Team) model is the most costly anesthesia model, which often has to be supplemented by the taxpayers of Washington. This model boosts Physician anesthesiologist salary up to 200% as they get to collect 50% of each of the 4 rooms they supervise. This is a huge financial incentive for the proponents of this bill but also an unnecessarily huge financial burden for taxpayers.

Second, AA legislation is the emerging trend by the ASA (American Society of Anesthesiologist) over recent years given that increased competition has increased tension between Physician Anesthesiologists and CRNAs. AAs have been legally in existence since the 1960s but it is only in recent years that MDA support has propped the effort up as CRNAs have continued to make progress. I have a document I can upload if you'd like that clearly shows reports from facilities in states where AAs practice where CRNAs are no longer hired and often driven out of a geographic market entirely. The ability for Physician Anesthesiologists to eliminate future competition by hiring AAs for a limited capacity service appears to be a long-term plan for Physician Anesthesiologist market dominance. AA legislation generates serious competitive concerns, and services to tip the scales only further towards the MDAs rather than level it. There are many regulatory advantages that MDAs have despite providing an identical anesthesia service.

I work in a rural facility in Port Angeles that integrates both independent CRNA and Independent MD services. We have no staffing issues. I also have personal knowledge that the hospitals around me in Forks, Port Townsend, Whitby, and Shelton, all of which are entirely serviced by CRNAs only, have no staffing shortages. Silverdale, where there are currently shortages, has a reason why those shortages exist. That reason being due to the way the Physician Anesthesiologist, who owns the contract, staff their facility needs. Often, these providers are working 55-60 hours a week. This has caused several providers to leave. Silverdale has both Physician and CRNA shortages/needs. This is a contract issue, not a legitimate short staffed issue.

There is a reason that 28 consecutive AA bills across this nation have failed, authorizing AAs licensure solves no problems, increases cost, decreases competition, and has safety concerns. AAs aren't the answer for other states and they are not the answer for Washington. All around authorizing AA licensure makes no logical sense. Please reject the application for licensure of anesthesiologist assistants.

Sincerely,

Daniel Slack, CRNA

Please reconsider allowing an another Anesthesiolgy entity into Washington State this is blatant attempt to damage the nurse anesthetist profession after more than 100 years serving the state especially rural under served area’s.

As a past president of WANA I know only too well needs for independent well trained CRNAs in this state and anti-competitive nature that AAs pose

Sincerely,
Patrick J Corbett

As a concerned healthcare provider I feel there is not a need for AA's in this state. First of all they can not practice independently so they are of no cost savings. Along with that they can not serve rural communities where there are solo practitioners. Anesthesia providers tend to congregate already in urban areas so there is not a need for them there. They are also not cost effective. They require supervision to the point they will not reduce costs in our healthcare system. They are of no benefit in poor and underserved areas. I encourage you to do what is best for this state. Sincerely, Elizabeth A Bruce CRNA MSN

My name is Aaron Hall. I am a CRNA in Spokane Washington. I would like to offer my position for your consideration regarding licensure of AA's in Washington state.

I will provide a little context for you. I recently needed an outlet installed for my utility room- the electrician that came said his background was in commercial installation (installing wiring when the walls were exposed) and that he would bring a partner in that had more experiencing working with existing wiring that sometimes require creative solutions. (The bid was $800 by the way for one outlet! Should have been an electrician!)

With the above illustration in mind- I would urge you to reject the any legislation licensing Anesthesia Assistants.

The more experienced electrician is already available in Washington state as CRNA's. Supporting our scope of practice will inherently benefit all Washingtonians.

And if you review any fiscal policy - paying 2 providers (AA and the Anesthesiologist to supervise them) as opposed to paying 1 (independent CRNA), makes little sense. Please be good stewards of our healthcare dollars - dollars which I contribute to Medicare and Medicaid every paycheck.

Thanks for your time

Aaron Hall

I, Rebecca Hartwig ,recently retired from a 34 year career as a Certified Registered Nurse Anesthetist. I am writing with concerns regarding the passage of legislation allowing the practice of anesthesia by Physician Assistants in the state of Washington.

CRNAs have a proven record of safety, practicing in various settings including the ability to practice independently. I have practiced in both settings, and I know from personal experience I relied heavily on my clinical judgment not only gained from experience but also from my previous experience as a Registered Nurse in the critical care setting. The education of a nurse anesthetist requires prior critical care experience before they are admitted to a certified program. The programs are accredited via a thorough and rigorous process. PAs will not have this background and their decision making will rely on the their education and the anesthesiologist they are working with. If that anesthesiologist is busy with

another task or anesthetic crisis, the PA will not be “supervised” and critical decision making will have to be made by a team member (PA) who may be far less qualified to do so.

There is a saying pertaining to anesthesia: It’s 90% boredom, 10% panic. When a crisis occurs, the patient needs a provider who can make a critical decision NOW to avoid a disastrous outcome. I often compared my day in the anesthesia seat to that of a pilot. When the plane is cruising , it seems anyone can fly the plane, but for the take off and landings (induction and emergence from anesthesia) you need experience, judgement and expertise, and when the plane is going down, (the patient is “coding” or is having a critical problem) you want someone who can think on their feet, not waiting to consult with an “expert”.

CRNAs have a proven safety record. Some things are best left alone. Please consider restricting the practice of Anesthesiologist Assistants in Washington state.

Thank you for your consideration.

Rebecca Hartwig, CRNA, ARNP, MSA

My name is Ryan Steed and I am one of the many certified registered nurse anesthetists (CRNAs) practicing here in the state of Washington and a member of the Washington Association of Nurse Anesthetists (WANA). I work for a small, critical access hospital with three other CRNAs to provide our community with high-quality, safe, and affordable anesthesia services 24 hours a day, 365 days a year. We offer up to date, evidence based anesthesia and analgesia that rivals and in many cases surpasses what is offered at larger hospitals and academic centers. We take pride in our work and in our connection with the people we serve. Again, this is all accomplished with four hard working, independent CRNAs. The hospital and people we care for receive premium service at a very reasonable cost. Similar situations are found in many hospitals throughout the state. If our hospital were to manage their anesthesia services with anesthesiologist assistants (AAs), the cost would be significantly higher both financially and in terms of quality and safety of care. AAs cannot work independently like CRNAs. They are required to function under the direct supervision of a physician anesthesiologist. This means that two people are required to do the same work as one CRNA. This means that every time an emergency is called after hours or an epidural is needed for a laboring patient, two providers have to be called in. The AA alone is not legally able to provide the services without the supervision of the physician anesthesiologist. You can see how this model quickly becomes unsustainable especially in the many rural settings here in our state.

Below is some additional information on why AAs do not improve access to care or safety for our communities. I would urge you to reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs). Thank you for your time and consideration.

Sincerely,

Ryan Steed, CRNA

ADDITIONAL INFORMATION

AAs do not improve access to care in Washington; in fact, there is reason to believe they will result in restricting access and driving up costs. AAs are narrowly trained and cannot practice without a licensed anesthesiologist. Finally, AAs are an unproven provider with no peer-reviewed studies that prove the safety of AAs.

Certified Registered Nurse Anesthetists (CRNAs) are certified anesthesia experts independently licensed to practice in all 50 states and the District of Columbia. Because of their extensive education and

training, CRNAs are permitted by federal and state laws and regulations to provide every type of anesthesia service to patients without the involvement or presence of a physician anesthesiologist. All research studies on anesthesia safety and cost-effectiveness conducted in the last 20 years confirm that CRNAs provide the safest, most cost-effective anesthesia care to patients.

In contrast, AAs can only practice in 15 states plus the District of Columbia. They are limited by their training and licensure to providing clinical support to anesthesiologists and may not practice "apart from the supervision of an anesthesiologist," according to the American Academy of Anesthesiologist Assistants (AAAA). Because AAs are required to be directly supervised by an anesthesiologist, the AA/anesthesiologist team is one of the costliest anesthesia delivery models with no scientific evidence of increased patient safety.

Because AAs cannot practice without anesthesiologist supervision, AAs do not practice in rural areas where CRNAs working without anesthesiologist involvement are the primary providers of anesthesia care. In fact, CRNAs are the only anesthesia provider in 72% of Washington's rural hospitals. AAs, in contrast, can only practice where anesthesiologists practice, which greatly limits their utilization. AAs, therefore, can't help solve problems of inadequate access to anesthesia care in rural and underserved communities.

If for any reason an AA's supervising anesthesiologist is not available, off-site, on vacation, or simply home for the day, the AA may not provide anesthesia care. The AA anesthesiologist- driven mode of practice, therefore, is inflexible and fails to adequately meet the needs of patients, hospitals, ambulatory surgical centers, or other healthcare settings.

While nurse anesthesia educational programs graduate nurse anesthetists prepared for autonomous practice, the AA program curriculum is characterized by training that only allows them to assist anesthesiologists in technical functions.

Because CRNAs do not need to practice with an anesthesiologist, they are much more cost effective than AAs. With an AA, the need exists to educate and use two providers – the supervising anesthesiologist and the AA – to provide anesthesia care to one patient. With a CRNA, only that individual is needed to provide total anesthesia care to the patient. Essentially, compared with the anesthesiologist-AA staffing arrangement, one CRNA can provide the care of two providers.

AAs are an unproven provider. No peer-reviewed studies in scientific journals have been published regarding the quality of care of AA practice or AA anesthesia outcomes. The quality of care that AAs provide is unproven, as there is no meaningful research data concerning AA anesthesia safety. In contrast, the excellent, safe anesthesia care that CRNAs provide and associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.

It makes no sense to authorize AAs, a less qualified anesthesia provider that can only work with anesthesiologists and can't be used in any area where anesthesiologists don't practice, such as many rural locations. Please reject the application for licensure of anesthesiologist assistants.

Ryan Steed

Regarding the Sunrise Review of AA's in Washington State, I urge you to oppose the addition of these new providers. In states where AA's are licensed, they cannot work without close and direct supervision by an anesthesiologist who bills for their services and reaps a portion of their collections.

They cost payers as much as other providers though. So, AA's would not save Washingtonians any money.

And, because they have to be osely supervised, AA's cannot extend care to Washingtonians who might otherwise not receive it.

AA's are not a good idea, unless you are an anesthesiologist who stands to make more money.

Thank you

Evan Koch

My name is Marwan Rayan and I am a practicing certified registered nurse anesthetist (CRNA) at the Providence Regional Medical Center in Everett, WA. I am writing to you in regards to the anesthesiologist assistant license review. I moved to WA state from TX where anesthesiologist assistants(AA) practice under physician anesthesiologist delegation and without appropriate licensure. I will explain why I oppose this bill and my opposition comes from my work with AAs and noticeable difference in anesthesia services from TX to WA, WA being significantly better.
It is not a question whether I like AAs or not but simply the question that poses itself is: do we need them and if we do, how do they fit in the WA state anesthesia world?
Working with AAs in Houston, TX I got to meet many of them and truly understand professionally who they are. Most of them did not have a background in healthcare prior to going to the assistant's school. Professions ranged from pet walker, au pair, etc to some with healthcare backgrounds such as respiratory therapist. I was a respiratory therapist prior to becoming a RN but explanation will follow. While every profession in which we earn an honest living is an honorable profession there is a difference between being an acute care/critical care RN and any other one held by AA. As a former respiratory therapist I went to RN school in order to learn more about critically ill patients and care they need. After graduating RT school I could have gone to AA school but quite honestly did not feel ready.
I felt that prior to learning about anesthesia I should know more about the patient as a whole and not just a cardiopulmonary system which I learned in RT school. Critical care nursing provided me with the ability, after graduating nursing school, to learn and incorporate the rest of the systems in order to provide complete care to my patients. Even after years in nursing from ICU to level I trauma ERs, I was still worried about the transition to ARNP- CRNA role. While I took a longer route to anesthesia then my fellow respiratory therapist that are now AAs, I must admit that it was the correct way to do it so patients receiving anesthesia will have a competent provider who understands how all these parts function together. Please do keep in mind that most AAs are not former respiratory therapists.
Now why are they not good for WA. Simply because they increase the cost without added value. Please allow me to elaborate. When I came to Everett I started working for a group that covers level II trauma centers with 50% physician anesthesiologist and 50% CRNAs as anesthesia providers. In this group we all do our own cases, there is no supervision nor medical direction, translated it means we all work. Physicians do their own cases while CRNAs do their own. What is the difference between my last job in Houston where I work under physician anesthesiologist direction and my current one where I practice independently? This model, independent CRNA, provides the most access to anesthesia care without any added cost nor added risk to patients.
Here in Everett we are significantly more efficient than in Houston.
There were many times in Houston where cases got canceled or delayed because there was no available physician anesthesiologist to supervise. Here we don't have to worry about it because instead of "supervising"we are all in rooms working. There is no reputable study to show any less care or safety when CRNAs practice independently. On the other hand, AAs have to work under physician anesthesiologist supervision which in turn will bring TX to WA and all the inefficiencies and delays will be an everyday occurrence. If we need more anesthesia providers, let's simply cancel medical direction/supervision of CRNAs and make everyone work. My second job is working at the eye surgery center. There I am the only anesthesia provider. AAs can't go there because there is no physician

anesthesiologist to supervise them. If they were to have one they would need to hire both AA and physician anesthesiologist to do the same job that I do by myself. Needless to say that cost would be unbearable to the clinic. Remember WA state is mostly rural and the vast majority of anesthesia providers in rural WA are CRNAs. By bringing AAs to WA state you will start a downward spiral in which anesthesia services will become more costly, there will be no added but lost value by having AAs who cannot practice to the extent of CRNAs. This will cause dissatisfaction in CRNAs that eventually may lead to CRNAs leaving urban and rural WA. You will have to replace those independent CRNAs such as myself with physician anesthesiologist medically directing AAs. This for sure will drive costs up since physician anesthesiologists make 2-3 times more than CRNA and AA makes the same as CRNA, and when you add potential for more mistakes due to less trained AAs you will be setting up WA state anesthesia practices for the failure.
I strongly urge you to oppose anesthesiologist assistant licensure in WA state as simply there is no need for them, not now not ever. Please take under your consideration my experience and let us keep WA state as the most progressive state in regards to healthcare. As you know TX does not fare very well in that regard. If you should allow AAs to practice in WA then you should allow CRNAs to supervise them. Again I do not believe there is a value in adding them to our team and I hope I made my argument clear.
Respectfully,

Marwan Rayan, CRNA

I am a Certified Registered Nurse Anesthetist currently working with Kaiser Permanente. I have 10 years of Anesthesia experience and many more years of Intensive Care Nursing experience at Harborview Medical Center. I am writing to you to shed some light on why it is very important to not allow Anesthesia Assistants to practice in our state. This push for AA's only benefits the pocket books of the Anesthesiologists supervising AA's and in no way benefits the patient or the healthcare system. Please allow me to outline some very sound arguments to consider and reject this sunrise review application.

1) Inefficient model:

AA's must work under direct supervision of an Anesthesiologist and have a fraction of the training of a CRNA and therefor would need to wait for the Anesthesiologist to perform the roles that a CRNA can do independently. This model leads to higher costs as all members of the operating room (surgeon, scrub techs, nurses wait with nothing to do until the Anesthesiologist can come be present). If a Anesthesiologist is managing four AA's and all the rooms start at the same time (which happens every day in surgery centers) then 3 rooms will be waiting 10-30 minutess while the room is ready to go. This adds more time to the operating room and payment for all parties presesnt. This is expensive for the healthcare system.

2) Not full service.

New graduates have less than 1/3 of Anesthesia training (not Masters level training). Both MD's and CRNA's training is in addition to years of hands on medical expirience. CRNA's have years of critical care experience which gives us proficiency with emergency situations. Only the cream of the crop are able to be admitted into these CRNA programs. These are the people who go on to become CRNA's and can then provide autonomous Anesthesia services. AA' have no particular required medical expirience.

3) High risk for Medicare Fraud-

AA practice must be billed as medical direction for maximum revenue generation and in order to avoid high risk for Medicare fraud. "Influence of supervision ratios by anesthesiologist on first case starts and critical portions of anesthetics" in the journal Anesthesiology found that 35% of the time a 1:2 supervision ratio the required medical direction (TERFA) rules were not being followed resulting in

medical fraud which could be easily be the case for medically directed AAs1. Facilities may also be at risk for Medicare fraud for not assuring appropriate medical direction for AAs, practices cannot afford this but neither can the facilities they serve.

4) Unsustainable costs-

The medical direction practice model is the most expensive and least efficient due to the requirement of one physician anesthesiologist for every four AAs/Nurse Anesthesiologist. While Nurse Anesthesiologists can work autonomously and can provide all the services needed at a lower cost with a proven equal level of safety. AA;s work in a 4:1 model. This additional cost of service requires large subsidies from the facility to maintain high cost anesthesia services.

We need to think of our mother or father on the table in the operating room. What kind of care would you want for them? AA's are not trained to make split second critical decisions. I would not want my family member to be under the care of someone who cannot care for them when something goes south in the operating room and a decision needs to be made instantly. The operating room is a place where a decision can change the outcome of a persons life. We need to take care with this and not make this just about money or efficiency but about quality safe healthcare. Everyone deserves to have a person who knows what to do, and can perform that task autonomously and not wait for someone to tell them what to do. This is unsafe. I ask you sunset panel, who would YOU want to have taking care of you? And if the answer is not an Anesthesia Assistant, then it would be unethical to vote to have become part of our Washington health care team.

Please vote for safety.

Erin Smith, CRNA

I encourage you to reject the application for licensure of anesthesiology assistants (AAs).

1. Educational requirements and clinical experience is insufficient compared to Certified Registered Nurse Anesthetists (CRNAs) and anesthesiologists. AAs prerequisite requirements are very similar to registered nurses (RNs) and physician assistants (PAs) who seek admission into an accredited nursing school or physicians assistant program. Once accepted into an AA program, the AA student can complete their degree in as little as 2-3 years. Therefore, an AA can go from a high school education to an anesthesiology assistant in as little as 4-5 years with little to no previous medical experience.

Similarly, a nursing student can complete a degree as a registered nurse in the same amount of time, 2-3 years and following completion of their prerequisites. A student can become a registered nurse in the same amount of time following high school, 4-5 years. HOWEVER, a nursing student must then work a minimum of 1-2 years, full-time, in an intensive care unit (ICU) PRIOR to applying to a nurse anesthesia program to become a CRNA. Once accepted into a CRNA program, the student registered nurse anesthetist (SRNA) must THEN complete an additional 2.5-3 years of education specializing in the field of anesthesia. The minimum amount of time required to become a CRNA after a high school education is 8.5 years-9 years (conservative minimum). That is MORE THAN TWICE the amount of education, experience, and training than an anesthesiology assistant.

Anesthesiologists complete 4 years of prerequisites prior to applying for a 4-year medical program which is then followed by an additional 3-4 years of anesthesia residency. Therefore, anesthesiologists will have completed a minimum of 11-12 years of education prior to obtaining their license.

In summary, AAs are significantly less educated and experienced than CRNAs and anesthesiologists.

2. There is NO literature to support the safety and efficacy of AAs in practice. However, there is sufficient research and evidence to support the safety and efficacy of CRNAs in practice.

3. Those in favor of the application claim AAs will help staff anesthesia care in rural areas. However, if you look at the statistics, CRNAs are the only anesthesia providers in SEVENTY-TWO PERCENT (72%) of Washington's rural hospitals. Whereas a CRNA can practice independently without an anesthesiologist, an anesthesiology assistant CANNOT. Therefore, the rural areas of Washington would need to SIGNIFICANTLY upstaff the number of anesthesiologists in order for AAs to work there. What is the current proposal or plan for staffing ratios with anesthesiologists and AAs? How many AAs can concurrently administer anesthesia under one anesthesiologist?

4. CRNAs can practice independently without the presence of an anesthesiologist. In contrast, AAs MUST work under an anesthesiologist. Not only are anesthesiologists exponentially more expensive to staff than CRNAs, but they will now require the additional costs of employing AAs to work underneath them. The staffing model/cost-effectiveness relationship would not make any financial sense in healthcare. However, the pros for anesthesiologists? Job security.

OVERALL (AAs) = SIGNIFICANTLY LESS EDUCATION AND EXPERIENCE + NO EVIDENCE + EXPONENTIALLY HIGHER HEALTHCARE COST + NO SOLUTION TO RURAL ANESTHESIA CARE

Shadhi Ajlani

I'm writing to discourage the approval of AA licensure in Washington state. Having never worked with one I can't speak to their technical competence but I imagine that like in any profession that there are good providers and bad and in the case of AAs that those with prior health care experience will be better than those without as the scope of training is extremely limited and they are trained only to assist an anesthesiologist.

I don't believe that they will solve anesthesia staffing in WA state and they will just bring another layer of complexity. It is already difficult for Anesthesiologists (MDAs) to meet the requirements when they are in a supervisory position or medical direction midel resulting in frequent unidentified fraud. Adding another provider type will only make this worse.

Because CRNAs are independently licensed we provide safe, efficient care anywhere in the state. Having AAs in small rural hospitals would require that hospital have 2 providers on site at all times one of whom would have be an MDA.

The solution to our staffing problems is more licensed independent providers (CRNAs and MDAs) and it is more economical to train CRNAs than MDAs because we fund our education 100% ourselves whereas an MDA is 50% funded by the government (resident salaries). If hospitals removed medical direction and supervision models and had all providers working independently this would increase anesthesia providers by 25% or more in our state and AAs cannot be a part of that solution with their limited scope of practice.

Thank you

Eileen Miller CRNA

My name is Sean B. Donohue, I am a resident of Pierce County and a retired service member of the U.S. Air Force. My wife is a Certified Registered Nurse Anesthetist (CRNA); therefore, I have

intimate knowledge of extensive and rigorous education and training, in addition to long hours of critical care nursing experience, to become a CRNA. I am writing this letter to express my opposition to the sunrise review application regarding licensure for anesthesiologist assistants (AA) in Washington. As a patient, I am very disappointed in your preliminary decision to approve the introduction of AA in our state.

I don't have special medical knowledge, unlike my wife, to evaluate clinicians who take care of me. Instead, I rely on your agency to ensure that people who take care of me are rigorously betted for approved education and training to uphold patient safety. Moreover, I rely on your agency to host a safe and efficient health care system in our state that will not jeopardize health care outcomes.

I do not understand why your agency has determined that AAs are safe to practice despite the lack of scientific evidence that supports their safety. Your reasoning, the lack of individual disciplinary cases involving AAs in other states, to introduce them to our state at the request of anesthesiologists is not enough for me to trust AAs. I consider their education and training are grossly inadequate compared to my wife's. What would happen to a patient who is taken care of by an AA in the operating room during a sudden emergency without their supervising anesthesiologist who cannot come help *soon enough*? My wife says it can be *very bad* for the patient. Airway emergency cannot even afford an extra two minutes without decisive and correct handling by a competent and well-trained anesthesia provider by their side. My wife says when airway goes, so do other important organs like brain. I do not trust AAs to keep my airway and brain safe during my surgery.

So please, reject AA licensure in Washington state.

Sincerely,

Sean B. Donohue, MBA

Lakewood, WA

I'm a resident of Yakima County in Washington. I recently had surgery in one of our local hospitals and I'm deeply concerned about the welfare and costs in our medical economy.

Please do not permit the licensure of Anesthesia Assistants in our state. AAs would require supervision by Anesthesiologists which means 2 providers would be needed rather than 1 CRNA. The CRNA model is the most cost-effective method for our state. Not to mention they are seasoned practitioners with more direct experience administering anesthesia than are the anesthesiologists themselves. I know this because I work closely with CRNAs and see that they are often the more qualified anesthesia provider than the anesthesiologists who "supervise".

Thank you for your time and consideration. Please consider the impact that this would have on CRNAs, their job opportunities, and our rising medical costs.

Thank you,

Angela Soffe

Music Artist

As a rural practicing certified registered nurse anesthetist (CRNA), business owner, and a member of the Washington Association of Nurse Anesthetists (WANA), I urge you to reject the sunrise review

application regarding licensure of anesthesiologist assistants (AAs). AA licensure will assuredly increase health care costs in Washington State, without increasing access to healthcare services. The AA education is narrow, and the training limited. They cannot practice without a licensed anesthesiologist on site. In addition, AAs are an unproven provider with no peer-reviewed studies that prove the safety of AAs.

Earlier this week I was called by a locums agency to provide anesthesia services at a local community hospital in my town (Yakima, WA). I worked at this hospital from 2013-2016 as a staff CRNA. After I was contacted by the locum recruiter I called the chief CRNA (Tim Parrish) and was told they were in a staffing crisis due to many CRNAs leaving the service. He also reported to me that none the physician anesthesiologists would agree to staff an OR suite, they refused to even in a staffing crisis. The culture of this facility is the CRNA runs the OR and the physician anesthesiologist "supervises"care from outside the operating room.

This type of staffing model is called an "Anesthesia Care Team" or ACT and it's being utilized all around the the country because it's financially beneficial to MD anesthesiologists. CMS allows anesthesiologists to "supervise" or bill 4 OR suites at one time. This is why the anesthesiologists are petitioning the Washington state DOH for AA licensure. It's not about solving work force gaps at all. It's about protecting the pocket book. There are plenty of anesthesia professionals between CRNAs and MDAs to solve all staffing crises in our state. The problem is a misuse of resources. It will not be solved with licensure of AAs.

All Certified Registered Nurse Anesthetists (CRNAs) are board certified anesthesia professionals licensed to practice in all 50 states and the District of Columbia. CRNAs were the first professionals to practice the specialty of anesthesiology in the USA. CRNAs have extensive education and training and are permitted by federal and state laws to provide every type of anesthesia service to patients without the involvement or presence of a physician anesthesiologist. All research studies on anesthesia safety and cost-effectiveness conducted in the last 20 years confirm that CRNAs provide the safest, most cost-effective anesthesia care to patients.

In contrast, AAs can only practice in 15 states plus the District of Columbia. They are limited by their training and licensure to providing clinical support to anesthesiologists and may not practice "apart from the supervision of an anesthesiologist," according to the American Academy of Anesthesiologist Assistants (AAAA). Because AAs are required to be directly supervised by an anesthesiologist, the AA/anesthesiologist team is one of the costliest anesthesia delivery models with no scientific evidence of increased patient safety.

Because AAs cannot practice without anesthesiologist supervision, AAs do not practice in rural areas where CRNAs working without anesthesiologist involvement are the primary providers of anesthesia care. In fact, CRNAs are the only anesthesia provider in 72% of Washington's rural hospitals. AAs, in contrast, can only practice where anesthesiologists practice, which greatly limits their utilization. AAs, therefore, cannot help solving problems of inadequate access to anesthesia care in rural and underserved communities.

I am a managing partner in a small private anesthesiology group providing anesthesia services to the medically underserved areas of Toppenish, Sunnyside, Moses Lake, and Ellensburg, WA. AAs would be completely useless in these communities and in our business. There is not a single practicing physician anesthesiologist living in any of these cities to supervise their care.

When an AA's supervising anesthesiologist is not available, off-site, on vacation, or simply home for the day, the AA may not provide anesthesia care. The AA anesthesiologist driven mode of practice, therefore, is inflexible and fails to adequately meet the needs of patients, hospitals, ambulatory surgical centers, or other healthcare settings. While nurse anesthesia educational programs graduate nurse anesthetists prepared for autonomous practice, the AA program curriculum is characterized by training that only allows them to assist anesthesiologists in technical functions (technicians).

CRNAs do not need to practice with an anesthesiologist, they are much more cost effective than AAs. With an AA, the need exists to educate and use two providers – the supervising anesthesiologist and the AA – to provide anesthesia care to one patient. With a CRNA, only that individual is needed to provide total anesthesia care to the patient. Essentially, compared with the anesthesiologist-AA staffing arrangement, one CRNA can provide the care of two providers.

AAs are an unproven provider. No peer-reviewed studies in scientific journals have been published regarding the quality of care of AA practice or AA anesthesia outcomes. The quality of care that AAs provide is unproven, as there is no meaningful research data concerning AA anesthesia safety. In contrast, the excellent, safe anesthesia care that CRNAs provide, and associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.

It makes no sense to authorize AAs, a less qualified anesthesia provider that can only work with anesthesiologists and cannot be used in any area where anesthesiologists do not practice, such as many rural locations. Please reject the application for licensure of anesthesiologist assistants.

Sincerely,

Spencer W. Soffe, CRNA, ARNP
Managing Partner
Evergreen Anesthesia Associates, LLC

As an anesthesiologist and Washington State citizen, I am writing to thank you for your draft Report to the Legislature finding in favor of the proposal to license certified anesthesiologist assistants (CAAs) in our state and to urge you to continue this favorable support in your final report. Currently, anesthesiologists have only one option for a non-physician anesthesia provider – authorizing CAAs to practice here would expand that option to include an additional provider. Moreover, it would bring additional qualified mid-level providers to our state, and importantly, would provide our patients with access to the benefits CAAs already provide to nearly 20 other jurisdictions. CAAs are highly trained master's degree level non-physician anesthesia care providers. They work under the medical direction of anesthesiologists to implement anesthesia care plans. CAAs work exclusively within the Anesthesia Care Team environment as described by ASA. The Anesthesia Care Team consists of a supervising anesthesiologist and from 1 to 4 non-physician anesthesia providers (i.e., CAAs, nurse anesthetists, or anesthesiology physician residents/fellows). All CAAs possess a premedical undergraduate background and complete a comprehensive didactic and clinical program at the graduate school master's degree level. They are trained extensively in the delivery and maintenance of quality anesthesia care as well as advanced patient monitoring techniques. Hospitals and related institutions seeking to utilize the Anesthesia Care Team approach to patient care should be authorized to do so with any qualified anesthesia provider under physician-led care and NOT be deprived the choice of qualified, medically-based trained CAAs. CAAs undergo rigorous and advanced graduate education in accredited master's degree programs ranging from 24 to 28 months, focusing on the Anesthesia Care Team approach to anesthesia practice. As a pre-requisite for admissions, applicants must hold a bachelor's degree, complete the same pre-medical course work that physicians complete, and score competitively in upper percentiles on the MCAT (Medical College Admission Test). CAAs are as safe and effective as nurse anesthetists and there is peer-reviewed, credible evidence to support this position. A 2018 study published in the peer-reviewed journal Anesthesiology confirmed the safety and efficacy of CAAs when it examined care between an anesthesiologist – nurse anesthetist team and an anesthesiologist – anesthesiologist assistant team. The results found "the specific composition of the anesthesia care team was not associated with any significant differences in mortality, length of stay, or inpatient spending." My anesthesiologist colleagues who work with both CAAs and nurse anesthetists can attest to the complete interchangeability of the two types of non-physician anesthesia providers. CAAs and nurse

anesthetists have identical patient care responsibilities and technical capabilities – a view in harmony with their equivalent treatment under the Medicare Program. I want to thank you for your initial draft finding in favor of licensing CAAs in Washington State and strongly urge you to continue to support this position as you draft the final report, for the reasons highlighted above. Thank you for your consideration.

Sincerely,

Dr. Sabrina C. Ward

I am a board-certified surgeon employed by a rural healthcare system. There are always CRNA's inmy operating room. I am very comfortable with their management of my patients. This proposal to provide anesthesia assistants concerns me. I do not know whether this is a scope of practice issue or a financial issue. I know that I would feel less comfortable with a less well trained individual managing my patient while being supervised by someone who manages several operating rooms from a different location.

Thanking you in advance for taking my thoughts under consideration, I remain

Sincerely

Davis L. Bronson, M.D.,FACS

I am writing to address the subject of Anaesthesia Assistants. As an Orthopaedic Surgeon practicing on the Kitsap and Olympic Pennisula since 1997, I cannot stress what a bad idea this is.

Medicine has lost much of its ability to control quality in the past 10 years and even more so, the past five years. The profession has not historically been really good at address failures of competence, but it is currently at an all time low. One of the reasons the system is broken is because we no longer assign value to things that are extremely important. As medicine is monopolized by large corporate structures, the individual practitioners are less invested and have less control.

To introduce a novel tier of practice into a system that has already become compromised dangerously threatens patient care. It undermines the value of what is being done when a patient is put to sleep for surgery.

I guarantee people will die unnecessarily, but the already blurred lines of accountability will explain it away.

Sincerely,

Gregory Duff MD

Orthopaedic Surgeon

I'm disappointed to have to write this letter about a topic that is why I moved to the state of Washington. I'm a Certified Registered Nurse Anesthetist, and I moved from Florida 3 years ago. One of the reasons I moved my family across the United States was for a better work environment and culture.

Before I moved to the state, I had the opportunity to work alongside Anesthesiologist Assistants (AAs), and I can assure you that it is not what the state of Washington needs. AAs are limited and restricted

providers that, instead of increasing access to anesthesia services, will decrease access and increase costs for Washingtonians.

Plenty of peer-reviewed studies show that CRNAs are as qualified as Physician Anesthesiologists delivering anesthesia care to all populations for 150 years. Physician Anesthesiologists created AAs to be able to control the anesthesia market for financial reasons. They made them in a way that AAs always require a Physician Anesthesiologist at all times.

In hospitals that AAs are introduced, they are introduced to push out or decreased the leverage that CRNAs have because CRNAs are not physician-dependent. This introduction is done to equalize CRNAs to AAs by limiting CRNAs scope of practice and education to the point that they either stay and practice with a very limited scope of practice or leave to other hospitals or other states.

I came to work at Providence in Everett because they have an anesthesia model that autonomously uses Physician Anesthesiologists and CRNAs. Every Physician and every CRNAs uses all their skills to take care of patients in a very collaborative and efficient manner.

The damage that the introduction of AAs would do to anesthesia care in Washington will be substantial in access to care, provider quality, and safety and disrupt a so far collegial relationship between Physician Anesthesiologists and CRNAs. Unlike the toxic and well-known animosity between these providers in states that have AAs.

We need more efficient, no more providers

The proponents are requesting licensure for Anesthesiologist Assistants because there is a somewhat belief "we need more providers." The reality is that the practices that use medical direction billing models are the most wasteful, least efficient, but financially beneficial for those practices that use this type of model. Suppose Washington requires hospitals with these models to become efficient by allowing Physician Anesthesiologists to practice anesthesia directly. In that case, we will suddenly be adding hundreds of qualified, local anesthesia providers that currently are not delivering direct care. Currently, they are being used as "supervisors" in a state that CRNAs don't need any supervision. AAs will not add more workforce to the state; it will allow those practices to replace CRNAs.

Fraud and bad business practices

Florida is definitely known for many great things, but it is also known for cultivating bad practices like fraudulent billing schemes against Medicare and Medicaid, and there has been plenty of issues with fraudulent anesthesia billing and medical direction. The American Society of Anesthesiologists reports that even the appropriate ratio of physician anesthesiologists to providers would result in lapses of supervision during critical portions of anesthetic cases. In a review of one year of data from a tertiary hospital, lapses occurred commonly during first-case starts, even with a 1:2 supervision ratio.

Fraudulent billing is not an issue with practices that allows CRNAs and Physician Anesthesiologists to work autonomously in collaboration. I would ask the health department to educate practices that still run this way to be more efficient and less-risk.

CRNAs supervising AAs

I think that if the panel is looking into increase the number of providers. They should look into allowing the supervision of AAs by CRNAs. Physicians and CRNAs, in the eyes of the law, practice at the same level, have no restrictions in every area of anesthesia care, and have been doing with excellent results. During this pandemic, CRNAs across the country and the state have step over areas like critical care and emergency services to support COVID-19 patients. They have been recognized as the most versatile and

adaptable provider by the Society of Critical Care Medicine and the National Academies of Science, Engineering, and Medicine.

It makes no sense to authorize AAs, a less qualified anesthesia provider that can only work with anesthesiologists and can't be used in any area where anesthesiologists don't practice, such as in many rural locations. Please reject the application for licensure of anesthesiologist assistants.

Respectfully,

Jonathan Alvarado, MS, ARNP, CRNA

> Influence of Supervision Ratios by Anesthesiologists on First-case Starts and Critical Portions of Anesthetics Richard H. Epstein, M.D., C.P.H.I, M.S.,* Franklin Dexter, M.D., Ph.D. Copyright © 2012, the American Society of Anesthesiologists, Inc. Lippincott Williams & Wilkins. Anesthesiology 2012; 116:683–91
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> See the 2010 study titled, "Cost-Effectiveness Analysis of Anesthesia Providers." [Hogan, P, Seifert, R, Moore, C, Simonson, B. "Cost-Effectiveness Analysis of Anesthesia Providers." Journal of Nursing Economic$. May/June 2010. 28, No. 3.
>
> 159-169.] See also the AANA White Paper titled, "Cost-Effectiveness of Nurse Anesthesia Practice," at https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2Fwww.aana.com%2Faboutus%2F&data=04%7C01%7Canesthesiology-sunrise%40doh.wa.gov%7C72fe6b1064494b360e0108d9861b19a3%7C11d0e217264e400a8ba057dcc127d72d%7C0%7C0%7C637688273686324075%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000&sdata=FztatBjlGvQ7kE8ClLL9JvZBgD2jrf898gEU4k90bVk%3D&reserved=0
>
> Pages/Resources,-About-AANA.aspx.

I strongly support this legislation in favor of CRNAs. In my deployed military assignments as a surgeon, CRNAs did not always have an anesthesia attending but continued to provide an invaluable service. Our Forward Surgical Teams were composed of four officers: three surgeons and a CRNA, a daunting responsibility CRNAs rose to for our casualties.

Dr. Suzan E. Marshall

Fmr MAJ, MC, US Army General Surgeon

Suzan E. Marshall, DO, C-MDI
Diplomat, American Board of Surgery
Certified Medicolegal Death Investigator

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I urge you to reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs). AAs do not improve access to care in Washington; in fact, there is reason to believe they will result in restricting access and driving up costs. AAs are narrowly trained and cannot practice without a licensed anesthesiologist. Finally, AAs are an unproven provider with no peer-reviewed studies that prove the safety of AAs.
Certified Registered Nurse Anesthetists (CRNAs) are certified anesthesia experts independently licensed to practice in all 50 states and the District of Columbia. Because of their extensive education and training, CRNAs are permitted by federal and state laws and regulations to provide every type of

anesthesia service to patients without the involvement or presence of a physician anesthesiologist. All research studies on anesthesia safety and cost-effectiveness conducted in the last 20 years confirm that CRNAs provide the safest, most cost-effective anesthesia care to patients.
In contrast, AAs can only practice in 15 states plus the District of Columbia. They are limited by their training and licensure to providing clinical support to anesthesiologists and may not practice "apart from the supervision of an anesthesiologist," according to the American Academy of Anesthesiologist Assistants (AAAA). Because AAs are required to be directly supervised by an anesthesiologist, the AA/anesthesiologist team is one of the costliest anesthesia delivery models with no scientific evidence of increased patient safety.
Because AAs cannot practice without anesthesiologist supervision, AAs do not practice in rural areas where CRNAs working without anesthesiologist involvement are the primary providers of anesthesia care. In fact, CRNAs are the only anesthesia provider in 72% of Washington's rural hospitals. AAs, in contrast, can only practice where anesthesiologists practice, which greatly limits their utilization. AAs, therefore, can't help solve problems of inadequate access to anesthesia care in rural and underserved communities.
If for any reason an AA's supervising anesthesiologist is not available, off-site, on vacation, or simply home for the day, the AA may not provide anesthesia care. The AA anesthesiologist- driven mode of practice, therefore, is inflexible and fails to adequately meet the needs of patients, hospitals, ambulatory surgical centers, or other healthcare settings.
While nurse anesthesia educational programs graduate nurse anesthetists prepared for autonomous practice, the AA program curriculum is characterized by training that only allows them to assist anesthesiologists in technical functions.
Because CRNAs do not need to practice with an anesthesiologist, they are much more cost effective than AAs. With an AA, the need exists to educate and use two providers – the

supervising anesthesiologist and the AA – to provide anesthesia care to one patient. With a CRNA, only that individual is needed to provide total anesthesia care to the patient. Essentially, compared with the anesthesiologist-AA staffing arrangement, one CRNA can provide the care of two providers.
AAs are an unproven provider. No peer-reviewed studies in scientific journals have been published regarding the quality of care of AA practice or AA anesthesia outcomes. The quality of care that AAs provide is unproven, as there is no meaningful research data concerning AA anesthesia safety. In contrast, the excellent, safe anesthesia care that CRNAs provide and associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.
It makes no sense to authorize AAs, a less qualified anesthesia provider that can only work with anesthesiologists and can't be used in any area where anesthesiologists don't practice, such as many rural locations. Please reject the application for licensure of anesthesiologist assistants.

Sincerely,
Amy Chaloux, CRNA

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I am extremely disappointed that the Department of Health is recommending anesthesiologist assistant licensure in its draft sunrise report. The public will not be protected by licensing anesthesiologist assistants (AAs). I urge you to change your recommendation and reject licensure of AAs.
The administration of anesthesia, including general anesthesia, has inherent risks to patients. These risks include pain, nausea and vomiting, laryngeal damage, anaphylaxis to anesthetic agents, cardiovascular collapse, respiratory depression, and dizziness. We must ensure that all anesthesia providers are safe to practice and are equipped with the skills to respond to medical emergencies. The administration of anesthesia is safe because of the skillset and training of the provider, their ability to immediately intervene to maintain patient stability, and continuously evaluate the interventions to maintain patient safety. A "simple anesthetic" does not exist.

AA education and training does not ensure the critical thinking skills necessary to respond to immediate patient emergencies. For example, there is no requirement for AAs to have any patient care experience prior to beginning their training. AAs do not have a broad foundation to reference when a patient's condition deteriorates. When life and death decisions are required, the operating surgeon will be forced to step in until the anesthesiologist, who is caring for other patients under anesthesia throughout a hospital, becomes available. This situation places the patient at immense risk at their most vulnerable of moments. Results will negatively impact the patient, provider, surgeon, and hospital.

Citizens of Washington State deserve proven, safe providers. The quality of care that AAs provide remains unknown; no meaningful research data exists concerning AA anesthesia quality and safety. The anesthesia care team model, which their supervision is mandated, is **inefficient**, **costly**, and concerning their lack of experience, would leave patients **vulnerable**.

In contrast, the excellent, safe anesthesia care that CRNAs offer with associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.

Washington state **must** support its existing, high quality anesthesia providers, CRNAs and physician anesthesiologists. Licensure for a narrowly trained provider with **limited usefulness** will not be beneficial in many healthcare settings, especially during our current COVID crisis. CRNAs are prepared to be instrumental in providing access to quality care while decreasing healthcare costs. Please reject licensure for anesthesiologist assistants.

Sincerely,

Ian Stoddard, CRNA

I thank you in advance for taking the time to review the full spectrum of data presented in order to continue to provide patients with the safe, consistent and time-tested standard of care which you have governed over so efficiently thus far. Knowing you'll want to continue this level of high quality care for our Washington patients, as a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I strongly urge you to reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs).

AAs do not improve access to care in Washington; in fact, there is reason to believe they will result in restricting access and driving up costs. AAs are narrowly trained and cannot practice without a licensed anesthesiologist. Finally, AAs are an unproven provider with no peer-reviewed studies that prove the safety of AAs.

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practice, therefore, is inflexible and fails to adequately meet the needs of patients, hospitals, ambulatory surgical centers, or other healthcare settings.
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supervising anesthesiologist and the AA – to provide anesthesia care to one patient. With a CRNA, only that individual is needed to provide total anesthesia care to the patient. Essentially, compared with the anesthesiologist-AA staffing arrangement, one CRNA can provide the care of two providers.
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It makes no sense to authorize AAs, a less qualified anesthesia provider that can only work with anesthesiologists and can't be used in any area where anesthesiologists don't practice, such as many rural locations. Please reject the application for licensure of anesthesiologist assistants.

Caring as deeply as I do for the safety of our patient community, and having spent nearly a decade and a half upholding this commitment to quality care, I feel that our current model is most effective and affordable without the inherent risk that this misguided power grab lends to at this time. Again, knowing your commitment to the same ideals toward patient advocacy, I feel confident in your supporting the only decision that has proven effective, that of a model not including AAs.

Sincerely,
Nicole Beaty, CRNA

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I urge you to reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs). AAs do not improve access to care in Washington; in fact, there is reason to believe they will result in restricting access and driving up costs. AAs are narrowly trained and cannot practice without a licensed anesthesiologist. Finally, AAs are an unproven provider with no peer-reviewed studies that prove the safety of AAs.

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Because AAs cannot practice without anesthesiologist supervision, AAs do not practice in rural areas where CRNAs working without anesthesiologist involvement are the primary providers of anesthesia care. In fact, CRNAs are the only anesthesia provider in 72% of Washington's rural hospitals. AAs, in contrast, can only practice where anesthesiologists practice, which greatly limits their utilization. AAs, therefore, can't help solve problems of inadequate access to anesthesia care in rural and underserved communities.

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Sincerely,

Robyn Thompson, CRNA

As a retired certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I urge you to reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs). AAs do not improve access to care in Washington; in fact, there is reason to believe they will result in restricting access and driving up costs. AAs are narrowly trained and cannot practice without a licensed anesthesiologist. Finally, AAs are an unproven provider with no peer-reviewed studies that prove the safety of AAs.

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Sincerely,

Mary Ann Frandsen, ARNP, CRNA (retired)

My name is Mariann Trice and I am an independently practicing nurse anesthetist in Washington State. I am a member of an all CRNA group that serves multiple ambulatory surgery centers and office -based practices just outside of Seattle. I live in Monroe, Washington.

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I urge you to reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs). AAs do not improve access to care in Washington; in fact, they will result in restricting access and driving up costs. AAs are narrowly trained and cannot practice without a licensed anesthesiologist.

With health care costs the way they are now, every anesthesia team member should be generating income by providing direct anesthesia services. A supervising physician is not generating income. AAs

must be supervised. That leads to unnecessary cost burdens to cover the costs of multiple anesthesia providers for one anesthetic.

CRNAs in contrast can work independently or in a collaborative model where both physician anesthesiologists and CRNAs each independently perform the anesthetics.

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All research studies on anesthesia safety and cost-effectiveness conducted in the last 20 years confirm that CRNAs provide the safest, most cost-effective anesthesia care to patients.

Any perceived shortage of anesthesia providers requires that physicians and CRNAs perform the anesthetics and bill for those cases. Unnecessary "supervision" accomplishes nothing except an extreme cost burden to cover the salary of the person performing the anesthesia and the costly supervisory position.

In contrast, AAs can only practice in 15 states plus the District of Columbia. They are limited by their training and licensure to provide clinical support to physician anesthesiologists. Because AAs are required to be directly supervised by an anesthesiologist, the AA/anesthesiologist team is one of the costliest anesthesia delivery models with no scientific evidence of increased patient safety- Paying for two providers to deliver one anesthetic.

Because AAs cannot practice without anesthesiologist supervision, AAs do not practice in rural areas where CRNAs work independently (without anesthesiologist involvement). CRNAs are the primary providers of anesthesia care. In fact, CRNAs are the only anesthesia provider in 72% of Washington's rural hospitals.

AAs, therefore, can't help solve problems of inadequate access to anesthesia care in rural and underserved communities.

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It makes no sense to authorize AAs, a less qualified anesthesia provider that can only work with physician anesthesiologists and can't be used in rural or critical access locations.

Please reject the application for licensure of anesthesiologist assistants.

Sincerely,

Mariann Trice, CRNA

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Sincerely, Timothy N. Haigh, DNP (c), CRNA

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driven mode of practice, therefore, is inflexible and fails to adequately meet the needs of patients, hospitals, ambulatory surgical centers, or other healthcare settings.
While nurse anesthesia educational programs graduate nurse anesthetists prepared for autonomous practice, the AA program curriculum is characterized by training that only allows them to assist anesthesiologists in technical functions.

Because CRNAs do not need to practice with an anesthesiologist, they are much more cost effective than AAs. With an AA, the need exists to educate and use two providers – the supervising anesthesiologist and the AA – to provide anesthesia care to one patient. With a CRNA, only that individual is needed to provide total anesthesia care to the patient. Essentially, compared with the anesthesiologist-AA staffing arrangement, one CRNA can provide the care of two providers.

AAs are an unproven provider. No peer-reviewed studies in scientific journals have been published regarding the quality of care of AA practice or AA anesthesia outcomes. The quality of care that AAs provide is unproven, as there is no meaningful research data concerning AA anesthesia safety. In contrast, the excellent, safe anesthesia care that CRNAs provide and associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.

It makes no sense to authorize AAs, a less qualified anesthesia provider that can only work with anesthesiologists and can't be used in any area where anesthesiologists don't practice, such as many rural locations. Please reject the application for licensure of anesthesiologist assistants.

Sincerely, Robert Velazquez, CRNA/APRN, MSNA

I am writing to ask you to reject the application for licensure of anesthesiologist assistants (AAs) . I am a Certified Registered Nurse Anesthetist (CRNA)who has practiced in Washington for 27 years. I have been active with my professional board, the Washington Association of Nurse Anesthetists (WANA) for my entire career. I have watched this political campaign driven by the American Association of Anesthesiologists (ASA). While trying to paint this an an increase in work force, it actually is a method to block CRNAs from jobs and guarantees ASA jobs , even if hospitals want to change staffing models. Authorizing AAs is a step backwards for health care in Washington state.

AAs can not practice without an anesthesiologist present , compared to CRNAs who practice all over the state. Did you know that CRNAs are the only Anestheisia provider in 72% of Washington's rural hospitals? Where do you think CRNAs get their experience to provide this level of expert anesthesia care? They get their experience in large medical centers that the ASA wants to staff with AAs.

There are no peer reviewed studies supporting the AA practice. There are many peer reviewed studies supporting CRNA practice. This makes no sense unless you are an anesthesiologist, it hurts everybody else to include the citizens of Washington state. I urge you to reject this application for what it is, a politically motivated move by the ASA to protect their incomes.

Respectfully, Mary Lawlor CRNA MAE

As a patient, I am disappointed in the Department of Health's (DOH) preliminary decision to approve the licensure of anesthesiologist assistants (AAs). I urge you to reconsider this decision and reject this sunrise review application.

As a now retired RN, I worked in the Operating Room for over 30 years alongside CRNA providers, who consistently practiced safely and independently in our small country hospital. They provided care where and when the MD anesthesia providers were not available, or willinginterested to travel to. Now I find myself in the position of health care consumer, and I rely on DOH to ensure that any health care provider that is licensed is safe to practice. I do not have the tools to do this myself, especially for such a specialized practice as anesthesia. DOH has determined that anesthesiologists and Certified Registered Nurse Anesthetists (CRNAs) have rigorous education and training requirements and have an incredible amount of evidence to support their safety as a health care provider.

However, for anesthesiologist assistants, DOH has not shown enough evidence to conclude that AAs are safe to practice. The DOH sunrise report cites only the lack of disciplinary cases in other states as the sole reason AAs are safe. That's not enough for me. Until there is clear evidence that AAs are safe, DOH should reject AA licensure.

Sincerely, Patricia Gregor

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I urge you to reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs). AAs do not improve access to care in Washington; in fact, there is reason to believe they will result in restricting access and driving up costs. AAs are narrowly trained and

cannot practice without a licensed anesthesiologist. Finally, AAs are an unproven provider with no peer-reviewed studies that prove the safety of AAs.

Certified Registered Nurse Anesthetists (CRNAs) are certified anesthesia experts independently licensed to practice in all 50 states and the District of Columbia. Because of their extensive education and training, CRNAs are permitted by federal and state laws and regulations to provide every type of anesthesia service to patients without the involvement or presence of a physician anesthesiologist. All research studies on anesthesia safety and cost-effectiveness conducted in the last 20 years confirm that CRNAs provide the safest, most cost-effective anesthesia care to patients.

In contrast, AAs can only practice in 15 states plus the District of Columbia. They are limited by their training and licensure to providing clinical support to anesthesiologists and may not practice "apart from the supervision of an anesthesiologist," according to the American Academy of Anesthesiologist Assistants (AAAA). Because AAs are required to be directly supervised by an anesthesiologist, the AA/anesthesiologist team is one of the costliest anesthesia delivery models with no scientific evidence of increased patient safety.

Because AAs cannot practice without anesthesiologist supervision, AAs do not practice in rural areas where CRNAs working without anesthesiologist involvement are the primary providers of anesthesia care. In fact, CRNAs are the only anesthesia provider in 72% of Washington's rural hospitals. AAs, in contrast, can only practice where anesthesiologists practice, which greatly limits their utilization. AAs, therefore, can't help solve problems of inadequate access to anesthesia care in rural and underserved communities.

If for any reason an AA's supervising anesthesiologist is not available, off-site, on vacation, or simply home for the day, the AA may not provide anesthesia care. The AA anesthesiologist- driven mode of practice, therefore, is inflexible and fails to adequately meet the needs of patients, hospitals, ambulatory surgical centers, or other healthcare settings.

While nurse anesthesia educational programs graduate nurse anesthetists prepared for autonomous practice, the AA program curriculum is characterized by training that only allows them to assist anesthesiologists in technical functions.

Because CRNAs do not need to practice with an anesthesiologist, they are much more cost effective than AAs. With an AA, the need exists to educate and use two providers – the supervising anesthesiologist and the AA – to provide anesthesia care to one patient. With a CRNA, only that individual is needed to provide total anesthesia care to the patient. Essentially, compared with the anesthesiologist-AA staffing arrangement, one CRNA can provide the care of two providers.

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It makes no sense to authorize AAs, a less qualified anesthesia provider that can only work with anesthesiologists and can't be used in any area where anesthesiologists don't practice, such as many rural locations. Please reject the application for licensure of anesthesiologist assistants.

Sincerely,

Paul Gregor, Doctor of Nurse Anesthesia Practice, CRNA, ARNP
CRNA Manager

As a retired certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I urge you to reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs). There is not a shortage of CRNA providers in Washington State therefore there is no need to introduce a poorly trained and limited class of anesthesia providers. AAs are narrowly trained and cannot practice without a licensed anesthesiologist. Certified Registered Nurse Anesthetists (CRNAs) are certified anesthesia experts independently licensed to practice in all 50 states and the District of Columbia. Because of their extensive education and training, CRNAs are permitted by federal and state laws and regulations to provide every type of anesthesia service to patients without the involvement or presence of a physician anesthesiologist. All research studies on anesthesia safety and cost-effectiveness conducted in the last 20 years confirm that CRNAs provide the safest, most cost-effective anesthesia care to patients. In contrast, AAs can only practice in 15 states plus the District of Columbia. They are limited by their training and licensure to providing clinical support to anesthesiologists and may not practice "apart from the supervision of an anesthesiologist," according to the American Academy of Anesthesiologist Assistants (AAAA). Because AAs are required to be directly supervised by an anesthesiologist, the AA/anesthesiologist team is one of the costliest anesthesia delivery models with no scientific evidence of increased patient safety. Because AAs cannot practice without anesthesiologist supervision, AAs do not practice in rural areas where CRNAs working without anesthesiologist involvement are the primary providers of anesthesia care. In fact, CRNAs are the only anesthesia provider in 72% of Washington's rural hospitals. AAs, in contrast, can only practice where anesthesiologists practice, which greatly limits their utilization. Because CRNAs do not need to practice with an anesthesiologist, they are much more cost effective than AAs. With an AA, the need exists to educate and use two providers – the supervising anesthesiologist and the AA – to provide anesthesia care to one patient.
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Please reject the application for licensure of anesthesiologist assistants.

Sincerely, Paul Hilliard, CRNA (Retired)

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I urge you to reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs). AAs do not improve access to care in Washington; in fact, there is reason to believe they will result in restricting access and driving up costs. AAs are narrowly trained and cannot practice without a licensed anesthesiologist. Finally, AAs are an unproven provider with no peer-reviewed studies that prove the safety of AAs.

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It makes no sense to authorize AAs, a less qualified anesthesia provider that can only work with anesthesiologists and can't be used in any area where anesthesiologists don't practice, such as many rural locations. Please reject the application for licensure of anesthesiologist assistants.

Sincerely, Kevin Chadburn, CRNA

As a student registered nurse anesthetist (SRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I urge you to reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs). AAs do not improve access to care in Washington; in fact, there is reason to believe they will result in restricting access and driving up costs. AAs are narrowly trained and cannot practice without a licensed anesthesiologist. Finally, AAs are an unproven provider with no peer-reviewed studies that prove the safety of AAs.

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Sincerely, Randi Arnoldi, RN, BSN, SRNA

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I urge you to reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs). AAs do not improve access to care in Washington; in fact, there is reason to believe they will result in **restricting access** and **driving up costs**. AAs are narrowly trained and cannot practice without a licensed anesthesiologist. AAs are an unproven provider with no peer-reviewed studies that prove the safety of AAs.

As a Certified Registered Nurse Anesthetist (CRNA), I am a certified anesthesia expert independently licensed to practice in all 50 states and the District of Columbia. Because of our extensive education and training, CRNAs are permitted by federal and state laws and regulations to provide every type of anesthesia service to patients without the involvement or presence of a physician anesthesiologist. All

research studies on anesthesia safety and cost-effectiveness conducted in the last 20 years confirm that CRNAs provide the safest, most cost-effective anesthesia care to patients.

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Due to the fact that AAs cannot practice without anesthesiologist supervision, AAs do not practice in rural areas where CRNAs working without anesthesiologist involvement are the primary providers of anesthesia care. In fact, CRNAs are the only anesthesia provider in 72% of Washington's rural hospitals. AAs, in contrast, can only practice where anesthesiologists practice, which greatly limits their utilization. AAs, therefore, **can't help solve problems of inadequate access to anesthesia care in rural and underserved communities**.

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Anesthesia Assistants are an unproven provider. No peer-reviewed studies in scientific journals have been published regarding the quality of care of AA practice or AA anesthesia outcomes. The quality of care that AAs provide is unproven, as there is no meaningful research data concerning AA anesthesia safety. In contrast, the excellent, safe anesthesia care that CRNAs provide and associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.

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This will be an expensive and costly mistake for the state and for hospitals, simply driving up the cost of healthcare at a time when we should be looking at ways of stopping the runaway costs associated with caring for our fellow humans. This is a decades-old turf war between doctors and nurses, with MDAs trying to find a way to guarantee they won't be replaced by CRNAs in the future, when in fact there are enough jobs and enough "pie" for everyone to practice anesthesia at this moment.

Please reject the application for licensure of anesthesiologist assistants.

Sincerely, Sarah Carter, CRNA

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I urge you to reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs). AAs do not improve access to care in Washington; in fact, there is reason to believe they will result in restricting access and driving up costs. AAs are narrowly trained and cannot practice without a licensed anesthesiologist. Finally, AAs are an unproven provider with no peer-reviewed studies that prove the safety of AAs.

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While nurse anesthesia educational programs graduate nurse anesthetists prepared for autonomous practice, the AA program curriculum is characterized by training that only allows them to assist anesthesiologists in technical functions.

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It makes no sense to authorize AAs, a less qualified anesthesia provider that can only work with anesthesiologists and can't be used in any area where anesthesiologists don't practice, such as many rural locations. Please reject the application for licensure of anesthesiologist assistants.

Sincerely, Greg Rigelman

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), **I urge you to reject** the sunrise review application regarding licensure for anesthesiologist assistants (AAs).

- AAs do not improve access to care in Washington; in fact, there is reason to believe they will result in restricting access and driving up costs.
- AAs are narrowly trained and cannot practice without a licensed anesthesiologist.
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Because AAs cannot practice without anesthesiologist supervision,

- AAs do not practice in rural areas where CRNAs working independently (without anesthesiologist) involvement are the primary providers of anesthesia care.
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I urge you to reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs).

Sincerely,
Randy R. Graybeal, MSN CRNA
Providence Regional Medical Center, Everett Staff CRNA

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I urge you to reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs). AAs do not improve access to care in Washington; in fact, there is reason to believe they will result in restricting access and driving up costs. AAs are narrowly trained and cannot practice without a licensed anesthesiologist. Finally, AAs are an unproven provider with no peer-reviewed studies that prove the safety of AAs.

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Sincerely, Jess Hammond, CRNA

I am a Certified Registered Nurse Anesthetist in Washington and an active member in good standing with the Washington Association of Nurse Anesthetists.

I am writing to urge you to reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs). Contrary to the suggestions that AAs will improve access to care in Washington, they will in fact restrict access and further increase health care costs. AAs do not have the extensive healthcare training and experience as advanced practice nurses such as CRNAs. AAs cannot practice without a licensed anesthesiologist present so the reimbursement is significantly higher as BOTH AAs and anesthesiologist will bill for their services. In addition, AA's are an unproven provider with no peer-reviewed studies that prove the safety of AAs.

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AAs are an unproven provider. No peer-reviewed studies in scientific journals have been published regarding the quality of care of AA practice or AA anesthesia outcomes. The quality of care that AAs provide is unproven, as there is no meaningful research data concerning AA anesthesia safety. In contrast, the excellent, safe anesthesia care that CRNAs provide and associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.

It makes no sense to authorize AAs, a less qualified anesthesia provider that can only work with anesthesiologists and can't be used in any area where anesthesiologists don't practice, such as many rural locations. Please reject the application for licensure of anesthesiologist assistants.

Sincerely, Anita Chan, MS Anesthesiology, CRNA

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I urge you to reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs). AAs do not improve access to care in Washington; in fact, there is reason to believe they will result in restricting access and driving up costs. AAs are narrowly trained and cannot practice without a licensed anesthesiologist. Finally, AAs are an unproven provider with no peer-reviewed studies that prove the safety of AAs.

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Sincerely, Stuart Godwin, CRNA

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Sincerely, Amy Hacker, CRNA

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It makes no sense to authorize AAs, a less qualified anesthesia provider that can only work with anesthesiologists and can't be used in any area where anesthesiologists don't practice, such as many rural locations. This inflexible staffing strategy does not improve patient care, access to care, or the rising cost of healthcare. Please reject the application for licensure of anesthesiologist assistants.

- Cameron Lovinger

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Sincerely, Kasey Kavanaugh

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Sincerely, Adam Dalgleish, CRNA

As a concerned healthcare provider I feel there is not a need for AA's in this state. First of all they can not practice independently so they are of no cost savings. Along with that they can not serve rural communities where there are solo practitioners. Anesthesia providers tend to congregate already in urban areas so there is not a need for them there. They are also not cost effective. They require supervision to the point they will not reduce costs in our healthcare system. They are of no benefit in poor and underserved areas. I encourage you to do what is best for this state.

Sincerely, Elizabeth A Bruce CRNA MSN

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Sincerely,

Aaron Eastman DNP, CRNA, ARNP
Managing Partner
Evergreen Anesthesia Associates LLC

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I am extremely disappointed that the Department of Health is recommending anesthesiologist assistant licensure in its draft sunrise report. The public will not be protected by licensing anesthesiologist assistants (AAs). I urge you to change your recommendation and reject licensure of AAs.

The administration of anesthesia, including general anesthesia, has inherent risks to patients. These risks include pain, nausea and vomiting, laryngeal damage, anaphylaxis to anesthetic agents, cardiovascular collapse, respiratory depression, and dizziness. We must ensure that all anesthesia providers are safe to practice and are equipped with the skills to respond to medical emergencies. The administration of anesthesia is safe because of the skillset and training of the provider, their ability to immediately intervene to maintain patient stability, and continuously evaluate the interventions to maintain patient safety. A "simple anesthetic" does not exist.

AA education and training does not ensure the critical thinking skills necessary to respond to immediate patient emergencies. For example, there is no requirement for AAs to have any patient care experience prior to beginning their training. AAs do not have a broad foundation to reference when a patient's condition deteriorates. When life and death decisions are required, the operating surgeon will be forced to step in until the anesthesiologist, who is caring for other patients under anesthesia throughout a hospital, becomes available. This situation places the patient at immense risk at their most vulnerable of moments. Results will negatively impact the patient, provider, surgeon, and hospital.

Citizens of Washington State deserve proven, safe providers. The quality of care that AAs provide remains unknown; no meaningful research data exists concerning AA anesthesia quality and safety. The anesthesia care team model, which their supervision is mandated, is inefficient, costly, and concerning their lack of experience, would leave patients vulnerable. In contrast, the excellent, safe anesthesia care that CRNAs offer with associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.

Washington state must support its existing, high quality anesthesia providers, CRNAs and physician anesthesiologists. Licensure for a narrowly trained provider with limited usefulness will not be beneficial in many healthcare settings, especially during our current COVID crisis. CRNAs are prepared to be instrumental in providing access to quality care while decreasing healthcare costs. Please reject licensure for anesthesiologist assistants.

Respectfully,

Brynn Delano, CRNA

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Sincerely, Benjamin Randell CRNA

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We, CRNAs, provide safe and efficient health care to our community and have done so for over 100 years. Nurse Anesthetists are proud to provide this care and our patients deserve to have the highest level care with CRNAs and MD Anesthesiologists.
Please reject the application for licensure of anesthesiologist assistants.

Sincerely, Heather TJ Christensen, CRNA

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AAs are an unproven provider. No peer-reviewed studies in scientific journals have been published regarding the quality of care of AA practice or AA anesthesia outcomes. The quality of care that AAs provide is unproven, as there is no meaningful research data concerning AA anesthesia safety. In contrast, the excellent, safe anesthesia care that CRNAs provide and associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.
It makes no sense to authorize AAs, a less qualified anesthesia provider that can only work with anesthesiologists and can't be used in any area where anesthesiologists don't practice, such as many rural locations. Please reject the application for licensure of anesthesiologist assistants.

Sincerely, Nathan A Williams, CRNA, MSN

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I urge you to reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs). AAs do not improve access to care in Washington; in fact, there is reason to believe they will result in restricting access and driving up costs. AAs are narrowly trained and cannot practice without a licensed anesthesiologist. Finally, AAs are an unproven provider with no peer-reviewed studies that prove the safety of AAs.

Certified Registered Nurse Anesthetists (CRNAs) are certified anesthesia experts independently licensed to practice in all 50 states and the District of Columbia. Because of their extensive education and training, CRNAs are permitted by federal and state laws and regulations to provide every type of anesthesia service to patients without the involvement or presence of a physician anesthesiologist. All research studies on anesthesia safety and cost-effectiveness conducted in the last 20 years confirm that CRNAs provide the safest, most cost-effective anesthesia care to patients.

In contrast, AAs can only practice in 15 states plus the District of Columbia. They are limited by their training and licensure to providing clinical support to anesthesiologists and may not practice "apart from the supervision of an anesthesiologist," according to the American Academy of Anesthesiologist Assistants (AAAA). Because AAs are required to be directly supervised by an anesthesiologist, the AA/anesthesiologist team is one of the costliest anesthesia delivery models with no scientific evidence of increased patient safety.

Because AAs cannot practice without anesthesiologist supervision, AAs do not practice in rural areas where CRNAs working without anesthesiologist involvement are the primary providers of anesthesia care. In fact, CRNAs are the only anesthesia provider in 72% of Washington's rural hospitals. AAs, in contrast, can only practice where anesthesiologists practice, which greatly limits their utilization. AAs, therefore, can't help solve problems of inadequate access to anesthesia care in rural and underserved communities.

If for any reason an AA's supervising anesthesiologist is not available, off-site, on vacation, or simply home for the day, the AA may not provide anesthesia care. The AA anesthesiologist-driven mode of practice, therefore, is inflexible and fails to adequately meet the needs of patients, hospitals, ambulatory surgical centers, or other healthcare settings. While nurse anesthesia educational programs graduate nurse anesthetists prepared for autonomous practice, the AA program curriculum is characterized by training that only allows them to assist anesthesiologists in technical functions.

Because CRNAs do not need to practice with an anesthesiologist, they are much more cost effective than AAs. With an AA, the need exists to educate and use two providers – the supervising anesthesiologist and the AA – to provide anesthesia care to one patient. With a CRNA, only that individual is needed to provide total anesthesia care to the patient. Essentially, compared with the anesthesiologist-AA staffing arrangement, one CRNA can provide the care of two providers.

AAs are an unproven provider. No peer-reviewed studies in scientific journals have been published regarding the quality of care of AA practice or AA anesthesia outcomes. The quality of care that AAs provide is unproven, as there is no meaningful research data concerning AA anesthesia safety. In contrast, the excellent, safe anesthesia care that CRNAs provide and associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.

It makes no sense to authorize AAs, a less qualified anesthesia provider that can only work with anesthesiologists and can't be used in any area where anesthesiologists don't practice, such as many rural locations. Please reject the application for licensure of anesthesiologist assistants.

Sincerely, Dr. Malika Bean, CRNA, DNAP

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I urge you to reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs). AAs do not improve access to care in Washington. AAs are trained only to practice under a licensed anesthesiologist and cannot practice independently. Currently there are no peer-reviewed studies that prove the safety of AAs.

In comparison, Certified Registered Nurse Anesthetists (CRNAs) are certified anesthesia experts independently licensed to practice in all 50 states and the District of Columbia. Following extensive education and training, CRNAs are permitted by federal and state laws and regulations to provide every type of anesthesia service to patients without the involvement or presence of a physician anesthesiologist. All research studies on anesthesia safety and cost-effectiveness conducted in the last 20 years confirm that CRNAs provide the safest, most cost-effective anesthesia care to patients.

In contrast, AAs can only practice in 15 states plus the District of Columbia. They are limited by their training and licensure to providing clinical support to anesthesiologists and may not practice "apart from the supervision of an anesthesiologist," according to the American Academy of Anesthesiologist Assistants (AAAA). AAs are required to be directly supervised by an anesthesiologist, therefore the AA/anesthesiologist team model is one of the most expensive anesthesia delivery models with no scientific evidence of increased patient safety.

AAs cannot practice without anesthesiologist supervision and can only practice where anesthesiologists practice, which greatly limits their utilization. For example; CRNAs are the sole anesthesia providers in 72% of Washington's rural hospitals. AAs, because of their supervision requirement, cannot practice in these rural community settings that do not employ anesthesiologists. AAs, therefore, cannot help solve problems of inadequate access to anesthesia care in rural and underserved communities.

If for any reason a supervising anesthesiologist is not available, the AA may not provide anesthesia care. The AA/anesthesiologist-driven mode of practice, therefore, is inflexible and fails to adequately meet the needs of patients, hospitals, ambulatory surgical centers, and other healthcare settings.

CRNAs do not need to practice with an anesthesiologist, and are therefore much more cost effective than the combination of AAs working under anesthesiologists. With an AA, two providers must be present to care for one patient (the AA and the supervising anesthesiologist). With a CRNA, only the CRNA is necessary to provide total anesthesia care to the patient.

In conclusion, AAs do not increase access to care in rural communities, they require supervision by a licensed anesthesiologist thereby increasing total cost in comparison to using a single provider and there are no peer-reviewed studies in scientific journals regarding the quality of care of AA practice or AA anesthesia outcomes. Therefore, it makes little sense to authorize the use of AAs in the state of Washington. Please reject the application for licensure of anesthesiologist assistants.

Respectfully, Kayla Marie Enquist DNAP, BSN, CRNA

As a certified registered nurse anesthetist (CRNA) and a member of the American Association of Nurse Anesthetists (AANA), I am extremely concerned that the Department of Health is recommending anesthesiologist assistant licensure in its draft sunrise report. This in fact will not help increase access to healthcare. In fact, it will hinder it as it will drive out well trained and highly educated CRNAs from practice sites in Washington. The public will not be protected by licensing anesthesiologist assistants (AAs).
I am writing strongly urging you to change your position and reject licensure of AAs.

CRNAs have long been on the forefront of anesthesia, and have been proven time and time again to be experts in the field, along with being safe and vigilant providers. The administration of anesthesia is safe because of the skillset and training of the provider, their ability to immediately intervene to maintain patient stability, and continuously evaluate the interventions to maintain patient safety. A "simple anesthetic" does not exist.
AA education and training does not ensure the critical thinking skills necessary to respond to immediate patient emergencies. For example, there is no requirement for AAs to have any patient care experience prior to beginning their training. AAs do not have a broad foundation to reference when a patient's condition deteriorates. When life and death decisions are required, the operating surgeon will be forced to step in until the anesthesiologist, who is caring for other patients under anesthesia throughout a hospital, becomes available. This situation places the patient at immense risk at their most vulnerable of moments. Results will negatively impact the patient, provider, surgeon, and hospital.

Citizens of Washington State deserve proven, safe, vigilant providers. The quality of care that AAs provide remains unknown; no meaningful research data exists concerning AA anesthesia quality and safety. The anesthesia care team model, which their supervision is mandated, is inefficient, costly, and concerning their lack of experience, would leave patients vulnerable. In contrast, the excellent, safe anesthesia care that CRNAs offer with associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.

Washington state must be a leader and support its existing, high quality anesthesia providers, CRNAs and physician anesthesiologists. CRNAs are prepared to be instrumental in providing access to quality care while decreasing healthcare costs. Please reject licensure for anesthesiologist assistants and protect the access to care of patients in the state of Washington.

Sincerely, Lauren Latuszek, CRNA, MSN

As a certified registered nurse anesthetist (CRNA), a member of the Washington Association of Nurse Anesthetists (WANA), and a member of the American Association of Nurse Anesthetists (AANA), I ask you to deny the sunrise review application regarding the introduction of licensure for anesthesiologist assistants (AAs) in Washington State. Currently in Washington State, anesthesia care is delivered effectively, and without shortage, by physician anesthesiologists and CRNAs; there is no shortage in access to anesthesia services in this state and therefore there is no need to introduce AAs. In fact, the introduction of AAs would not improve access to care and would effectively drive-up costs of anesthesia services since AAs cannot practice independently without a licensed anesthesiologist. The quality of anesthesia care should be highly questioned when associated with AAs due to their unproven track record in other states, inferior educational standards, and no peer-reviewed studies to prove their safety and cost effectiveness.

Currently in Washington all anesthesia care is delivered either by a Medical Doctor in the specialty of

Anesthesia - an anesthesiologist, or by a masters or doctorate prepared advanced practice nurse in the specialty of Anesthesia – a CRNA. Both anesthesiologists and CRNAs are licensed to provide a full scope of anesthesia services independently in this state, without the supervision of each other. The safety and cost effectiveness of anesthesia services provided by physician anesthesiologists and CRNAs independently is well documented and has proven itself over the course of time. There is not believed to be a shortage in anesthesia services in Washington state, especially in the rural areas due to the ability of CRNAs to provide independent full scope anesthesia care. AAs would not increase access to anesthesia services in Washington because they cannot provide a full scope of anesthesia and must be closely supervised by an onsite anesthesiologist. In effect, by utilizing an AA, you would be replacing a single independent provider (CRNA or anesthesiologist) with the need for two providers (an AA and supervising anesthesiologist). The work of one would now become the work of two, increasing cost to the hospitals, clinics, Medicare, Medicaid, and ultimately to patients.

Additionally, the educational standards for AAs should be highly scrutinized. Most AA programs do not require any patient care experience or an undergraduate degree in healthcare prior to admittance into the program. Because AAs are not fully trained as physician assistants (PAs), American Academy of Physician Assistants (AAPA) opposes states to characterize AA as PAs. PAs are intensely trained in generalized medical education and can often transition easily among specialties; whereas AAs are not trained generally in medicine and are only trained to deliver anesthesia care as part of a care team under anesthesiologist direction. AAs and PAs sit for different national certification examinations and therefore hold unequal certifications. In contrast, the training of anesthesiologists and CRNAs is time proven, well rounded, and comprehensive. Prior to admission to CRNA school, the applicant must have a bachelor's degree in nursing and have at a minimum of 2 years of critical care nursing experience in intensive care units. The anesthesia education for CRNAs extends 2.5 – 4 years beyond the undergraduate nursing degree and includes more than 2,000 hours of clinical anesthesia experience beyond didactic education. Most CRNA education programs produce doctoral degrees as most master's programs are transitioning to doctorate level programs.

The safety of AAs is unproven. There are no peer-reviewed studies that have been published regarding the safety and quality of anesthesia care when provided by an AA in a care team model. AAs limited generalized medical training and limited prior patient care or experience in healthcare justify the questioning of safety in AA practice. In contrast, the excellence in providing safe and cost-effective anesthesia care, and expanding access to full scope of anesthesia services has been repeatedly documented in peer-reviewed studies and published in prominent scientific and healthcare journals.

Considering cost, quality of care and patient safety, I ask you to please reject the application for licensure of AAs in Washington state.

Sincerely, Dr. Elizabeth Davison, DNAP, CRNA

As a certified registered nurse anesthetist (CRNA) at Harborview Medical Center, graduate of Gonzaga's Doctor of Nurse Anesthesia Program and a member of the Washington Association of Nurse Anesthetists (WANA), I urge you to reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs). AAs do not improve access to care in Washington; in fact, there is reason to believe they will result in restricting access and driving up costs. AAs are narrowly trained and cannot practice without a licensed anesthesiologist. Finally, AAs are an unproven provider with no peer-reviewed studies that prove the safety of AAs.

Certified Registered Nurse Anesthetists (CRNAs) are certified anesthesia experts independently licensed to practice in all 50 states and the District of Columbia. Because of their extensive education and training, CRNAs are permitted by federal and state laws and regulations to provide every type of anesthesia service to patients without the involvement or presence of a physician anesthesiologist. All

research studies on anesthesia safety and cost-effectiveness conducted in the last 20 years confirm that CRNAs provide the safest, most cost-effective anesthesia care to patients.

In contrast, AAs can only practice in 15 states plus the District of Columbia. They are limited by their training and licensure to providing clinical support to anesthesiologists and may not practice "apart from the supervision of an anesthesiologist," according to the American Academy of Anesthesiologist Assistants (AAAA). Because AAs are required to be directly supervised by an anesthesiologist, the AA/anesthesiologist team is one of the costliest anesthesia delivery models with no scientific evidence of increased patient safety.

Because AAs cannot practice without anesthesiologist supervision, AAs do not practice in rural areas where CRNAs working without anesthesiologist involvement are the primary providers of anesthesia care. In fact, CRNAs are the only anesthesia provider in 72% of Washington's rural hospitals. AAs, in contrast, can only practice where anesthesiologists practice, which greatly limits their utilization. AAs, therefore, can't help solve problems of inadequate access to anesthesia care in rural and underserved communities.

If for any reason an AA's supervising anesthesiologist is not available, off-site, on vacation, or simply home for the day, the AA may not provide anesthesia care. The AA anesthesiologist- driven mode of practice, therefore, is inflexible and fails to adequately meet the needs of patients, hospitals, ambulatory surgical centers, or other healthcare settings.

While nurse anesthesia educational programs graduate nurse anesthetists prepared for autonomous practice, the AA program curriculum is characterized by training that only allows them to assist anesthesiologists in technical functions.

Because CRNAs do not need to practice with an anesthesiologist, they are much more cost effective than AAs. With an AA, the need exists to educate and use two providers – the

supervising anesthesiologist and the AA – to provide anesthesia care to one patient. With a CRNA, only that individual is needed to provide total anesthesia care to the patient. Essentially, compared with the anesthesiologist-AA staffing arrangement, one CRNA can provide the care of two providers.

AAs are an unproven provider. No peer-reviewed studies in scientific journals have been published regarding the quality of care of AA practice or AA anesthesia outcomes. The quality of care that AAs provide is unproven, as there is no meaningful research data concerning AA anesthesia safety. In contrast, the excellent, safe anesthesia care that CRNAs provide and associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.

It makes no sense to authorize AAs, a less qualified anesthesia provider that can only work with anesthesiologists and can't be used in any area where anesthesiologists don't practice, such as many rural locations. Please reject the application for licensure of anesthesiologist assistants.

Sincerely, Christa Kirby DNAP, CRNA, ARNP

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I urge you to reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs). AAs do not improve access to care in Washington; in fact, there is reason to believe they will result in restricting access and driving up costs. AAs are narrowly trained and cannot practice without a licensed anesthesiologist. Finally, AAs are an unproven provider with no peer-reviewed studies that prove the safety of AAs.

Certified Registered Nurse Anesthetists (CRNAs) are certified anesthesia experts independently licensed to practice in all 50 states and the District of Columbia. Because of their extensive education and training, CRNAs are permitted by federal and state laws and regulations to provide every type of anesthesia service to patients without the involvement or presence of a physician anesthesiologist. All research studies on anesthesia safety and cost-effectiveness conducted in the last 20 years confirm that CRNAs provide the safest, most cost-effective anesthesia care to patients.

In contrast, AAs can only practice in 15 states plus the District of Columbia. They are limited by their training and licensure to providing clinical support to anesthesiologists and may not practice "apart from the supervision of an anesthesiologist," according to the American Academy of Anesthesiologist Assistants (AAAA). Because AAs are required to be directly supervised by an anesthesiologist, the AA/anesthesiologist team is one of the costliest anesthesia delivery models with no scientific evidence of increased patient safety.

Because AAs cannot practice without anesthesiologist supervision, AAs do not practice in rural areas where CRNAs working without anesthesiologist involvement are the primary providers of anesthesia care. In fact, CRNAs are the only anesthesia provider in 72% of Washington's rural hospitals. AAs, in contrast, can only practice where anesthesiologists practice, which greatly limits their utilization. AAs, therefore, can't help solve problems of inadequate access to anesthesia care in rural and underserved communities.

If for any reason an AA's supervising anesthesiologist is not available, off-site, on vacation, or simply home for the day, the AA may not provide anesthesia care. The AA anesthesiologist- driven mode of practice, therefore, is inflexible and fails to adequately meet the needs of patients, hospitals, ambulatory surgical centers, or other healthcare settings.

While nurse anesthesia educational programs graduate nurse anesthetists prepared for autonomous practice, the AA program curriculum is characterized by training that only allows them to assist anesthesiologists in technical functions.

Because CRNAs do not need to practice with an anesthesiologist, they are much more cost effective than AAs. With an AA, the need exists to educate and use two providers – the supervising anesthesiologist and the AA – to provide anesthesia care to one patient. With a CRNA, only that individual is needed to provide total anesthesia care to the patient. Essentially, compared with the anesthesiologist-AA staffing arrangement, one CRNA can provide the care of two providers.

AAs are an unproven provider. No peer-reviewed studies in scientific journals have been published regarding the quality of care of AA practice or AA anesthesia outcomes. The quality of care that AAs provide is unproven, as there is no meaningful research data concerning AA anesthesia safety. In contrast, the excellent, safe anesthesia care that CRNAs provide and associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.

It makes no sense to authorize AAs, a less qualified anesthesia provider that can only work with anesthesiologists and can't be used in any area where anesthesiologists don't practice, such as many rural locations. Please reject the application for licensure of anesthesiologist assistants.

Feliz Diaz

I am a bioinformatics scientist, teaching in the Providence Sacred Heart Medical Center/Gonzaga University Nurse Anesthesia Program. Our three year graduate program in nursing anesthesia includes an extensive commitment to critically appraising research evidence to inform clinical practice. We require the highest levels of evidence to guide practice.

The research evidence guiding composition of anesthesia teams is lacking. The single retrospective analysis of claims data referenced in this field found no statistically significant difference in mortality, length of stay, and costs between two types of care teams (physician anesthesiologist plus nurse anesthetist or anesthesiologist assistant) . The cohorts were comparable in many demographic and clinical case characteristics. Statistical differences were appropriately assessed for effect sizes.

Multivariable models confirmed the unadjusted findings. The ratio of anesthesiologist assistant cases to cases utilizing nurse anesthetists was very low.

I am not surprised by the lack of a relationship between anesthesia care team composition and outcomes of mortality, length of stay costs. The most appropriate care outcomes to examine include those most important to our patients: postoperative pain, nausea and vomiting, laryngeal damage, anaphylaxis to anesthetic agents, cardiovascular collapse, respiratory depression, and dizziness. The administration of effective anesthesia care has risks to our patients. Considering changes to team composition must rely on the highest quality evidence, examining care outcomes most important to our patients.

The quality of care that anesthesiologist assistants provide remains unknown. The anesthesia care that CRNAs offer with important patient outcomes have been repeatedly demonstrated in peer-reviewed studies. Washington state must support its existing, high quality anesthesia providers, CRNAs and physician anesthesiologists. Please reject licensure for anesthesiologist assistants until sufficient evidence warrants a practice change.

Kenn B. Daratha, PhD
Bioinformatics Scientist
Providence Medical Research Center
Doctoral Faculty
Providence Sacred Heart Medical Center/Gonzaga University Nurse Anesthesia Program

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I am a Certified Registered Nurse Anesthesiologist(CRNA). I have practiced anesthesia in Washington state for the past 35 years. I urge you to reject the sunrise review application regarding licensure for anesthesiologist assistants(AAs).

AAs are only allowed to practice in 15 states in the US. In contrast, CRNA's are licensed in all 50 states and allowed to practice completely independent of any physician supervision in 19 states. AAs cannot practice at all without the direct supervision of a physician anesthesiologist. This severely limits how AAs can be utilized and requires that 2 people are required to give an anesthetic. This is not true when a CRNA is involved with an anesthetic. This is a very expensive and archaic way to provide anesthesia services.

AAs are also unproven healthcare providers. No peer-reviewed studies have shown that AAs are safe and effective providers of anesthesia care.

It makes no sense to authorize and license AAs, a less qualified anesthesia provider with an unproven safety record. AAs will cost more and be less flexible than increasing the use of CRNAs, especially in times of increased need of anesthesia providers.

Please reject the application for licensure of anesthesiologist assistants.

Sincerely, Robert D. Poaster CRNA, MA

As a Certified Registered Nurse Anesthetist (CRNA), a member of the Washington Association of Nurse Anesthetists (WANA), and a member of the American Association of Nurse Anesthetists (AANA), I ask you to deny the sunrise review application regarding the introduction of licensure for Anesthesiologist Assistants (AAs) in Washington State. Currently in Washington State anesthesia care is delivered

effectively, and without shortage, by Anesthesiologists and CRNAs; there is no shortage in access to anesthesia services in this state and therefor no need to introduce AAs. In fact, the introduction of AAs would not improve access to care and would effectively drive-up costs of anesthesia services since AAs cannot practice independently without a licensed anesthesiologist. The quality of anesthesia care should be highly questioned when associated with AAs due to their unproven track record in other states, inferior educational standards, and no peer-reviewed studies to prove their safety and cost effectiveness.

Currently in Washington all anesthesia care is delivered either by a Medical Doctor in the specialty of Anesthesia - an Anesthesiologist (MDA), or by a Master's or Doctorate prepared Advanced Practice Nurse in the specialty of Anesthesia – a CRNA. Both MDAs and CRNAs are licensed to provide a full scope of anesthesia services independently in this state, without the supervision of each other. The safety and cost effectiveness of anesthesia services provided by MDAs and CRNAs independently is well documented and has proven itself over the course of time. There is not believed to be a shortage in anesthesia services in Washington state, especially in the rural areas due to the ability of CRNAs to provide independent full scope anesthesia care.

AAs would not increase access to anesthesia services in Washington because they cannot provide a full scope of anesthesia and must be closely supervised by an onsite anesthesiologist. In effect, by utilizing an AA, you would be replacing a single independent provider (CRNA or MDA) with the need for two providers, an AA and supervising anesthesiologist. The work of one would now become the work of two, increasing cost to the hospitals, clinics, Medicare, Medicaid, and ultimately patients.

The educational standards for AAs should be highly scrutinized. Most AA programs do not require any patient care experience or an undergraduate degree in healthcare prior to admittance into the program. Because AAs are not fully trained as physician assistants (PAs), American Academy of physician Assistants (AAPA) opposes states to characterize AA as PAs. PAs are intensely trained in generalized medical education and can often transition easily among specialties; whereas AAs are not trained generally in medicine and are only trained to deliver anesthesia care as part of a care team under anesthesiologist direction. AAs and PAs sit for different national certification examinations and therefor hold unequal certifications. In contrast the training of MDAs and CRNAs is time proven, well rounded, and comprehensive. Prior to admission to CRNA school, the applicant must have a bachelor's degree in nursing and have at a minimum of 2 years of critical care nursing experience in intensive care units. The anesthesia education for CRNAs extends 2.5 – 4 years beyond the undergraduate nursing degree and includes more than 2,000 hours of clinical anesthesia experience beyond didactic education. Most CRNA education programs produce doctoral degrees as most master's programs are transitioning to doctorate level programs.

The safety of AAs is unproven. There are no peer-reviewed studies that have been published regarding the safety and quality of anesthesia care when provided by an AA in a care team model. AAs limited generalized medical training and limited prior patient care or experience in healthcare justify the questioning of safety in AA practice. In contrast, the excellence in providing safe and cost-effective anesthesia care, and expanding access to full scope of anesthesia services has been repeatedly documented in peer-reviewed studies and published in prominent scientific and healthcare journals.

When considering the sunrise review for the introduction of AAs in Washington state I urge you to think about who you would want to provide anesthesia care for yourself, your child, your parent, or your other loved ones. Do you want an under-educated AA who cannot provide the full scope of anesthesia services without close supervision of an Anesthesiologist? Or do you want a time proven provider with a vast experience in providing critical patient care with a high-quality anesthesia specialized education? Please protect the patients in Washington state from the unsafe, unnecessary introduction of AAs in Washington. As a citizen of, and a CRNA in Washington state, I ask you to reject the application for licensure of anesthesiologist assistants.

Sincerely, Jackie Bates, CRNA, MSNA, ARNP

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I urge you to reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs). AAs do not improve access to care in Washington; in fact, there is reason to believe they will result in restricting access and driving up costs. AAs are narrowly trained and cannot practice without a licensed anesthesiologist. Finally, AAs are an unproven provider with no peer-reviewed studies that prove the safety of AAs.

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In contrast, AAs can only practice in 15 states plus the District of Columbia. They are limited by their training and licensure to providing clinical support to anesthesiologists and may not practice "apart from the supervision of an anesthesiologist," according to the American Academy of Anesthesiologist Assistants (AAAA). Because AAs are required to be directly supervised by an anesthesiologist, the AA/anesthesiologist team is one of the costliest anesthesia delivery models with no scientific evidence of increased patient safety.

Because AAs cannot practice without anesthesiologist supervision, AAs do not practice in rural areas where CRNAs working without anesthesiologist involvement are the primary providers of anesthesia care. In fact, CRNAs are the only anesthesia provider in 72% of Washington's rural hospitals. AAs, in contrast, can only practice where anesthesiologists practice, which greatly limits their utilization. AAs, therefore, can't help solve problems of inadequate access to anesthesia care in rural and underserved communities.

If for any reason an AA's supervising anesthesiologist is not available, off-site, on vacation, or simply home for the day, the AA may not provide anesthesia care. The AA anesthesiologist- driven mode of practice, therefore, is inflexible and fails to adequately meet the needs of patients, hospitals, ambulatory surgical centers, or other healthcare settings.

While nurse anesthesia educational programs graduate nurse anesthetists prepared for autonomous practice, the AA program curriculum is characterized by training that only allows them to assist anesthesiologists in technical functions.

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It makes no sense to authorize AAs, a less qualified anesthesia provider that can only work with anesthesiologists and can't be used in any area where anesthesiologists don't practice, such as many rural locations. Please reject the application for licensure of anesthesiologist assistants.

Best regards, Tressa Adams

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I urge you to reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs). AAs do not improve access to care in Washington; in fact, there is reason to believe they will result in restricting access and driving up costs. AAs are narrowly trained and cannot practice without a licensed anesthesiologist. Finally, AAs are an unproven provider with no peer-reviewed studies that prove the safety of AAs.

I am currently working as an independent provider, meaning without an anesthesiologist. An AA would not be able to provide services where I do. I improve access to care by making it more affordable for my current facilities to provide anesthesia services. By operating in an outpatient setting, we also relieve burdens on the hospital system. Allowing AAs to practice in WA will increase the cost of anesthesia services for hospitals and it does not unburden the CAH because those facilities already struggle to employ anesthesiologists due to their inability to fund their salaries. CAH benefit more from anesthesia providers who function independently so they are not paying two providers for one anesthetic.

Certified Registered Nurse Anesthetists (CRNAs) are certified anesthesia experts independently licensed to practice in all 50 states and the District of Columbia. Because of their extensive education and training, CRNAs are permitted by federal and state laws and regulations to provide every type of anesthesia service to patients without the involvement or presence of a physician anesthesiologist. All research studies on anesthesia safety and cost-effectiveness conducted in the last 20 years confirm that CRNAs provide the safest, most cost-effective anesthesia care to patients.
In contrast, AAs can only practice in 15 states plus the District of Columbia. They are limited by their training and licensure to providing clinical support to anesthesiologists and may not practice “apart from the supervision of an anesthesiologist,” according to the American Academy of Anesthesiologist Assistants (AAAA). Because AAs are required to be directly supervised by an anesthesiologist, the AA/anesthesiologist team is one of the costliest anesthesia delivery models with no scientific evidence of increased patient safety.

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If for any reason an AA’s supervising anesthesiologist is not available, off-site, on vacation, or simply home for the day, the AA may not provide anesthesia care. The AA anesthesiologist- driven mode of practice, therefore, is inflexible and fails to adequately meet the needs of patients, hospitals, ambulatory surgical centers, or other healthcare settings.

While nurse anesthesia educational programs graduate nurse anesthetists prepared for autonomous practice, the AA program curriculum is characterized by training that only allows them to assist anesthesiologists in technical functions.
Because CRNAs do not need to practice with an anesthesiologist, they are much more cost effective than AAs. With an AA, the need exists to educate and use two providers – the supervising anesthesiologist and the AA – to provide anesthesia care to one patient. With a CRNA, only that individual is needed to provide total anesthesia care to the patient. Essentially, compared with the anesthesiologist-AA staffing arrangement, one CRNA can provide the care of two providers.

AAs are an unproven provider. No peer-reviewed studies in scientific journals have been published regarding the quality of care of AA practice or AA anesthesia outcomes. The quality of care that AAs provide is unproven, as there is no meaningful research data concerning AA anesthesia safety. In

contrast, the excellent, safe anesthesia care that CRNAs provide and associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.
It makes no sense to authorize AAs, a less qualified anesthesia provider that can only work with anesthesiologists and can't be used in any area where anesthesiologists don't practice, such as many rural locations. Please reject the application for licensure of anesthesiologist assistants.

Sincerely, Rebecca Markle, ARNP, CRNA, MSN

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I urge you to reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs). AAs do not improve access to care in Washington; in fact, there is reason to believe they will result in restricting access and driving up costs. AAs are narrowly trained and cannot practice without a licensed anesthesiologist. Finally, AAs are an unproven provider with no peer-reviewed studies that prove the safety of AAs.
Certified Registered Nurse Anesthetists (CRNAs) are certified anesthesia experts independently licensed to practice in all 50 states and the District of Columbia. Because of their extensive education and training, CRNAs are permitted by federal and state laws and regulations to provide every type of anesthesia service to patients without the involvement or presence of a physician anesthesiologist. All research studies on anesthesia safety and cost-effectiveness conducted in the last 20 years confirm that CRNAs provide the safest, most cost-effective anesthesia care to patients.
In contrast, AAs can only practice in 15 states plus the District of Columbia. They are limited by their training and licensure to providing clinical support to anesthesiologists and may not practice "apart from the supervision of an anesthesiologist," according to the American Academy of Anesthesiologist Assistants (AAAA). Because AAs are required to be directly supervised by an anesthesiologist, the AA/anesthesiologist team is one of the costliest anesthesia delivery models with no scientific evidence of increased patient safety.
Because AAs cannot practice without anesthesiologist supervision, AAs do not practice in rural areas where CRNAs working without anesthesiologist involvement are the primary providers of anesthesia care. In fact, CRNAs are the only anesthesia provider in 72% of Washington's rural hospitals. AAs, in contrast, can only practice where anesthesiologists practice, which greatly limits their utilization. AAs, therefore, can't help solve problems of inadequate access to anesthesia care in rural and underserved communities.
If for any reason an AA's supervising anesthesiologist is not available, off-site, on vacation, or simply home for the day, the AA may not provide anesthesia care. The AA anesthesiologist- driven mode of practice, therefore, is inflexible and fails to adequately meet the needs of patients, hospitals, ambulatory surgical centers, or other healthcare settings.
While nurse anesthesia educational programs graduate nurse anesthetists prepared for autonomous practice, the AA program curriculum is characterized by training that only allows them to assist anesthesiologists in technical functions.
Because CRNAs do not need to practice with an anesthesiologist, they are much more cost effective than AAs. With an AA, the need exists to educate and use two providers , the supervising anesthesiologist and the AA , to provide anesthesia care to one patient. With a CRNA, only that individual is needed to provide total anesthesia care to the patient. Essentially, compared with the anesthesiologist-AA staffing arrangement, one CRNA can provide the care of two providers.
During my career, I have practiced in a setting utilizing anesthesiologist assistants and I can attest to the fact that they are undertrained and unsafe providers. They are not required to have a degree in the medical field or any medical training prior to admittance to the AA training program. Despite the design of the anesthesiologist-AA model of care, the MD cannot always be present to manage the inexperienced care an AA provides. I have witnessed this and it terrifies me. I myself would never accept care from an AA.

If this application for licensure is accepted, I fear that my family and friends as well as my community may suffer under the care of an AA. Please reject the application.

Sincerely, Kristen Weckenbrock, BSN, MSN, CRNA

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I urge you to reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs). AAs do not improve access to care in Washington; in fact, there is reason to believe they will result in restricting access and driving up costs. AAs are narrowly trained and cannot practice without a licensed anesthesiologist. Finally, AAs are an unproven provider with no peer-reviewed studies that prove the safety of AAs.

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AAs are an unproven provider. No peer-reviewed studies in scientific journals have been published regarding the quality of care of AA practice or AA anesthesia outcomes. The quality of care that AAs provide is unproven, as there is no meaningful research data concerning AA anesthesia safety. In contrast, the excellent, safe anesthesia care that CRNAs provide and associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.

It makes no sense to authorize AAs, a less qualified anesthesia provider that can only work with anesthesiologists and can't be used in any area where anesthesiologists don't practice, such as many rural locations.

Please reject the application for licensure of anesthesiologist assistants.

Sincerely, Mary Edwards, MS, CRNA

As a certified registered nurse anesthetist (CRNA) and a member of the American Association of Nurse Anesthetists (AANA), I am extremely concerned that the Department of Health is recommending anesthesiologist assistant licensure in its draft sunrise report. This in fact will not help increase access to healthcare. In fact, it will hinder it as it will drive out well trained and highly educated CRNAs from practice sites in Washington. The public will not be protected by licensing anesthesiologist assistants (AAs).

I am writing strongly urging you to change your position and reject licensure of AAs.

CRNAs have long been on the forefront of anesthesia, and have been proven time and time again to be experts in the field, along with being safe and vigilant providers. The administration of anesthesia is safe because of the skillset and training of the provider, their ability to immediately intervene to maintain patient stability, and continuously evaluate the interventions to maintain patient safety. A "simple anesthetic" does not exist.

AA education and training does not ensure the critical thinking skills necessary to respond to immediate patient emergencies. For example, there is no requirement for AAs to have any patient care experience prior to beginning their training. AAs do not have a broad foundation to reference when a patient's condition deteriorates. When life and death decisions are required, the operating surgeon will be forced to step in until the anesthesiologist, who is caring for other patients under anesthesia throughout a hospital, becomes available. This situation places the patient at immense risk at their most vulnerable of moments. Results will negatively impact the patient, provider, surgeon, and hospital.

Citizens of Washington State deserve proven, safe, vigilant providers. The quality of care that AAs provide remains unknown; no meaningful research data exists concerning AA anesthesia quality and safety. The anesthesia care team model, which their supervision is mandated, is inefficient, costly, and concerning their lack of experience, would leave patients vulnerable. In contrast, the excellent, safe anesthesia care that CRNAs offer with associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.

Washington state must be a leader and support its existing, high quality anesthesia providers, CRNAs and physician anesthesiologists. CRNAs are prepared to be instrumental in providing access to quality care while decreasing healthcare costs. Please reject licensure for anesthesiologist assistants and protect the access to care of patients in the state of Washington.

Sincerely, Laura Franks Gal , CRNA, MSN

As a certified registered nurse anesthetist (CRNA) and a member of the American Association of Nurse Anesthetists (AANA), I am extremely concerned that the Department of Health is recommending anesthesiologist assistant licensure in its draft sunrise report. This in fact will not help increase access to healthcare. In fact, it will hinder it as it will drive out well trained and highly educated CRNAs from

practice sites in Washington. The public will not be protected by licensing anesthesiologist assistants (AAs).
I am writing strongly urging you to change your position and reject licensure of AAs.

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AA education and training does not ensure the critical thinking skills necessary to respond to immediate patient emergencies. For example, there is no requirement for AAs to have any patient care experience prior to beginning their training. AAs do not have a broad foundation to reference when a patient's condition deteriorates. When life and death decisions are required, the operating surgeon will be forced to step in until the anesthesiologist, who is caring for other patients under anesthesia throughout a hospital, becomes available. This situation places the patient at immense risk at their most vulnerable of moments. Results will negatively impact the patient, provider, surgeon, and hospital.

Citizens of Washington State deserve proven, safe, vigilant providers. The quality of care that AAs provide remains unknown; no meaningful research data exists concerning AA anesthesia quality and safety. The anesthesia care team model, which their supervision is mandated, is inefficient, costly, and concerning their lack of experience, would leave patients vulnerable. In contrast, the excellent, safe anesthesia care that CRNAs offer with associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.

Washington state must be a leader and support its existing, high quality anesthesia providers, CRNAs and physician anesthesiologists. CRNAs are prepared to be instrumental in providing access to quality care while decreasing healthcare costs. Please reject licensure for anesthesiologist assistants and protect the access to care of patients in the state of Washington.

Sincerely, Amanda Patz, CRNA, MSN

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), ***I am extremely disappointed that the Department of Health is recommending anesthesiologist assistant licensure in its draft sunrise report.*** The public will not be protected by licensing anesthesiologist assistants (AAs). ***I urge you to change your recommendation and reject licensure of AAs.***

The administration of anesthesia, including general anesthesia, has inherent risks to patients. At worst, this includes cardiovascular collapse, respiratory depression, neurological damage, and anaphylaxis to anesthetic agents. The administration of anesthesia is safe because of the skillset and training of the provider. We must ensure that all anesthesia providers are safe to practice and are equipped with the skills to respond to anesthetic and surgical emergencies.

AA education and training does not ensure the critical thinking skills necessary to respond to immediate patient emergencies. There is no requirement for AAs to have any patient care experience prior to beginning their training. AAs do not have a broad foundation to reference when a patient's condition deteriorates. When life and death decisions are required, the operating surgeon – who has no anesthesia training – will be forced to step in until the anesthesiologist, who is caring for other patients under anesthesia throughout a hospital, becomes available. ***This situation places the patient at immense risk at the most dangerous time.***

Citizens of Washington State deserve proven, safe providers. The quality of care that AAs provide remains unknown; ***no meaningful research data exists concerning AA quality and safety***. Because AA supervision is mandated, it is inefficient, costly, and potentially dangerous. In contrast, excellent and safe anesthesia care that CRNAs offer has been repeatedly demonstrated in peer-reviewed studies published in prominent journals.

Washington state must support its existing, high quality anesthesia providers, CRNAs and physician anesthesiologists. Licensure for a narrowly trained provider with limited usefulness is harmful in many healthcare settings, especially during our current COVID crisis. CRNAs are prepared to be instrumental in providing access to quality care while decreasing healthcare costs. Please reject licensure for anesthesiologist assistants.

Sincerely yours, Julia W. Schafer, CRNA

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I urge you to reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs). AAs do not improve access to care in Washington; in fact, there is reason to believe they will result in restricting access and driving up costs. AAs are narrowly trained and cannot practice without a licensed anesthesiologist. Finally, AAs are an unproven provider with no peer-reviewed studies that prove the safety of AAs.

Certified Registered Nurse Anesthetists (CRNAs) are certified anesthesia experts independently licensed to practice in all 50 states and the District of Columbia. Because of their extensive education and training, CRNAs are permitted by federal and state laws and regulations to provide every type of anesthesia service to patients without the involvement or presence of a physician anesthesiologist. All research studies on anesthesia safety and cost-effectiveness conducted in the last 20 years confirm that CRNAs provide the safest, most cost-effective anesthesia care to patients.

In contrast, AAs can only practice in 15 states plus the District of Columbia. They are limited by their training and licensure to providing clinical support to anesthesiologists and may not practice “apart from the supervision of an anesthesiologist,” according to the American Academy of Anesthesiologist Assistants (AAAA). Because AAs are required to be directly supervised by an anesthesiologist, the AA/anesthesiologist team is one of the costliest anesthesia delivery models with no scientific evidence of increased patient safety.

Because AAs cannot practice without anesthesiologist supervision, AAs do not practice in rural areas where CRNAs working without anesthesiologist involvement are the primary providers of anesthesia care. In fact, CRNAs are the only anesthesia provider in 72% of Washington’s rural hospitals. AAs, in contrast, can only practice where anesthesiologists practice, which greatly limits their utilization. AAs, therefore, can’t help solve problems of inadequate access to anesthesia care in rural and underserved communities.

If for any reason an AA’s supervising anesthesiologist is not available, off-site, on vacation, or simply home for the day, the AA may not provide anesthesia care. The AA anesthesiologist- driven mode of practice, therefore, is inflexible and fails to adequately meet the needs of patients, hospitals, ambulatory surgical centers, or other healthcare settings.

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AAs are an unproven provider. No peer-reviewed studies in scientific journals have been published regarding the quality of care of AA practice or AA anesthesia outcomes. The quality of care that AAs

provide is unproven, as there is no meaningful research data concerning AA anesthesia safety. In contrast, the excellent, safe anesthesia care that CRNAs provide and associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals. It makes no sense to authorize AAs, a less qualified anesthesia provider that can only work with anesthesiologists and can't be used in any area where anesthesiologists don't practice, such as many rural locations. Please reject the application for licensure of anesthesiologist assistants.

Sincerely, Melissa Hudson, DNP, CRNA

As a current student in the Doctorate of Nurse Anesthesia Practice through Gonzaga University, I am extremely disappointed that the Department of Health is recommending anesthesiologist assistant licensure in its draft sunrise report. The public will not be protected by licensing anesthesiologist assistants (AAs). I urge you to change your recommendation and reject licensure of AAs.

The administration of anesthesia, including general anesthesia, has inherent risks to patients. These risks include pain, nausea and vomiting, laryngeal damage, anaphylaxis to anesthetic agents, cardiovascular collapse, respiratory depression, and dizziness. These risks come with otherwise healthy patients. For patients with multiple and complex diseases, these risks can increase by two/three-fold. We must ensure that all anesthesia providers are safe to practice and are equipped with the skills to respond to medical emergencies. The administration of anesthesia is safe because of the skillset and training of the provider, their ability to immediately intervene to maintain patient stability, and continuously evaluate the interventions to maintain patient safety. A "simple anesthetic" does not exist.

AA education and training does not ensure the critical thinking skills necessary to respond to immediate patient emergencies. For example, there is no requirement for AAs to have any patient care experience prior to beginning their training. I was a nurse at the bedside in the intensive care unit for almost 7 years before attending nurse anesthesia school. Nurses that choose to further their career in nurse anesthesia are required to have ICU level training and a fundamental set of critical thinking skills to care for patients before even entering anesthesia school. AAs do not have a broad foundation to reference when a patient's condition deteriorates. By the end of my three-year training, I will have over 2,000 clinical hours that have been facilitated by preceptors from both CRNAs (certified registered nurse anesthetists) and anesthesiologists. When life and death decisions are required, the operating surgeon will be forced to step in until the anesthesiologist, who is caring for other patients under anesthesia throughout a hospital, becomes available. As a previous bedside nurse, I know first-hand that there are situations where you cannot wait for the MD to be present to act. The surgeon may be able to step in but will not know why this patient is deteriorating unless the cause is specifically due to surgical inventions that just took place. The surgeon will need to get a report from the AA who may not be able to provide pertinent information for the surgeon to come up with a differential diagnosis for why this patient is deteriorating. Surgeons are also acutely focused on the procedure itself and may not readily be able to recall the comorbidities of the patient, thus needing time to get a report from the AA. When in an emergent situation, you do not have time for this and need to be able to act with critical thinking skills that have been developed over the course of your professional career not only as a CRNA but from your time as a nurse at the bedside. When AAs cannot make critical decisions in deteriorating situations, it places the patient at immense risk at their most vulnerable of moments.

Citizens of Washington State deserve proven, safe providers. The quality of care that AAs provide remains unknown; no meaningful research data exists concerning AA anesthesia quality and safety. The anesthesia care team model, which their supervision is mandated, is inefficient, costly, and concerning their lack of experience, would leave patients vulnerable. In contrast, the excellent, safe anesthesia care

that CRNAs offer with associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.

Washington state must support its existing, high quality anesthesia providers, CRNAs and physician anesthesiologists. Licensure for a narrowly trained provider with limited usefulness will not be beneficial in many healthcare settings, especially during our current COVID crisis. CRNAs are prepared to be instrumental in providing access to quality care while decreasing healthcare costs. Please reject licensure for anesthesiologist assistants.

Sincerely,

Laura Bast BSN, RN, CCRN, SRNA
Providence Sacred Heart Medical Center and Gonzaga University
Doctorate of Nurse Anesthesia Practice Candidate, Class of 2024

As family nurse practitioners, we are extremely disappointed in the Department of Health's (DOH) preliminary decision to approve the licensure of anesthesiologist assistants (AAs). We urge you to reconsider this decision and reject this sunrise review application.

Patient safety is my top priority. As the owners of a family practice, we refer patients for surgery under the care of Certified Registered Nurse Anesthetists (CRNAs) and anesthesiologists. Both providers practice as independent providers, and both provide safe care to our patients.

The administration of anesthesia, including general anesthesia, has inherent risks to patients. These serious risks include pain, nausea and vomiting, heart attack, and stroke. We must ensure that all anesthesia providers are safe to practice and are equipped with the skills to respond to medical emergencies. The administration of anesthesia is safe because of the skillset and training of the provider, their ability to immediately intervene to maintain patient stability, and continuously evaluate the interventions to maintain patient safety.

The DOH draft sunrise report concludes that AA practice is safe, based on the lack of disciplinary cases in the states that credential AAs. However, the DOH sunrise review does not cite any additional evidence that affirms the safety of AA practice. Given the inherent serious risks to anesthesia administration, without any additional evidence of safe AA practice, the sunrise review application should be rejected. If you are going to support a new class of anesthesia providers, we would like to see data from randomized controlled studies published in peer-reviewed journals, as a minimum level of evidence, not the lack of disciplinary cases.

The health of my patients and all patients undergoing surgery in Washington is at stake.
Sincerely,

Bob Smithing, MSN, FNP, FAANP
Gallup Poll: Nurses rated highest among professions for honesty and ethics for the 21st straight year!

Clinical Director, FamilyCare of Kent a Nurse Managed Center
Adjunct Faculty, Seattle Pacific University, School of Nursing
Clinical Faculty, Pacific Lutheran University, School of Nursing
Affiliate Instructor, University of Washington, School of Nursing
Clinical Affiliate Faculty, Seattle University
Executive Director, ARNPs United of Washington State

As a surgeon, I am disappointed in the Department of Health's (DOH) preliminary decision to approve the licensure of anesthesiologist assistants (AAs).

I urge you to reconsider this decision and reject this sunrise review application. Patient safety is my top priority. I work with Certified Registered Nurse Anesthetists (CRNAs) and anesthesiologists. Both providers practice as independent providers in my facility, and both provide safe care to my patients. The administration of anesthesia, including general anesthesia, has inherent risks to patients. These serious risks include pain, nausea and vomiting, heart attack, and stroke. We must ensure that all anesthesia providers are safe to practice and are equipped with the skills to respond to medical emergencies. The administration of anesthesia is safe because of the skillset and training of the provider, their ability to immediately intervene to maintain patient stability, and continuously evaluate the interventions to maintain patient safety. The DOH draft sunrise report concludes that AA practice is safe, based on the lack of disciplinary cases in the states that credential AAs. However, the DOH sunrise review does not cite any additional evidence that affirms the safety of AA practice. Given the inherent serious risks to anesthesia administration, without any additional evidence of safe AA practice, the sunrise review application should be rejected.

Sincerely, Dr. Bob Conroy, MD, FACS

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I am extremely disappointed that the Department of Health is recommending anesthesiologist assistant licensure in its draft sunrise report. The public will not be protected by licensing anesthesiologist assistants (AAs). I urge you to change your recommendation and reject licensure of AAs.

The administration of anesthesia, including general anesthesia, has inherent risks to patients. These risks include pain, nausea and vomiting, laryngeal damage, anaphylaxis to anesthetic agents, cardiovascular collapse, respiratory depression, and dizziness. We must ensure that all anesthesia providers are safe to practice and are equipped with the skills to respond to medical emergencies. The administration of anesthesia is safe because of the advanced skills and training of the provider, their ability to immediately intervene to maintain patient stability, and continuously evaluate the interventions to maintain patient safety. A "simple anesthetic" does not exist.

AA education and training does not ensure the critical thinking skills necessary to respond to immediate patient emergencies. For example, there is no requirement for AAs to have any healthcare experience, let alone direct patient care experience prior to beginning their training. AAs do not have a strong foundation to reference when a patient's condition deteriorates. When life and death decisions are required and every second matters, the operating surgeon will be forced to step in until the anesthesiologist, who is caring for other patients under anesthesia throughout a hospital, becomes available. This situation places the patient at immense risk in their most vulnerable moments. This will negatively impact the patient, provider, surgeon, and hospital.

Citizens of Washington State deserve proven, safe providers. Patient safety is the number one priority. The quality of care that AAs provide remains unknown; no meaningful research data exists concerning AA anesthesia quality and safety. We do know their experience and training are insufficient compared to CRNAs and physician anesthesiologists. The anesthesia care team model, which the AA supervision requirement mandates, is inefficient, costly, and concerning due to their lack of experience. In contrast, the excellent, safe anesthesia care that CRNAs offer with associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.

Washington state must support its existing, high quality anesthesia providers, CRNAs and physician anesthesiologists. Licensure for a narrowly trained provider with limited usefulness will not be beneficial in many healthcare settings, especially during our current COVID crisis. CRNAs are prepared to be instrumental in providing access to quality care while decreasing healthcare costs. Please reject licensure for anesthesiologist assistants.

Sincerely, Kelsey Rust, CRNA

As a patient, I am disappointed in the Department of Health's (DOH) preliminary decision to approve the licensure of anesthesiologist assistants (AAs). I urge you to reconsider this decision and reject this sunrise review application.

I am not a health care provider, but I am a healthcare consumer. I rely on DOH to ensure that any health care provider that is licensed is safe to practice. I do not have the tools to do this myself, especially for such a specialized practice as anesthesia. DOH has determined that anesthesiologists and Certified Registered Nurse Anesthetists (CRNAs) have rigorous education and training requirements and have an incredible amount of evidence to support their safety as a health care provider.

However, for anesthesiologist assistants, DOH has not shown enough evidence to conclude that AAs are safe to practice. The DOH sunrise report cites only the lack of disciplinary cases in other states as the sole reason AAs are safe. That's not enough for me. Until there is clear evidence that AAs are safe, DOH should reject AA licensure.

Sincerely, Josh Rust

I am a Certified Registered Nurse Anesthetist (CRNA) working in Washington state and a member of the Washington Association of Nurse Anesthetists (WANA). I work at a small critical access hospital (CAH) in Othello, Washington. We are staffed solely by CRNA's working independently to care for the members of our entire county. We provide a great service to our community, from our obstetric practice to stabilizing the very sick or trauma victims, enabling safe transfer to larger facilities. Our hospital would not be fiscally viable utilizing a team care approach to anesthesia.

I am extremely disappointed that the Department of Health is recommending anesthesiologist assistant licensure in its draft sunrise report. The public will not be protected by licensing anesthesiologist assistants (AAs). I urge you to change your recommendation and reject licensure of AAs.

The administration of anesthesia, including general anesthesia, has inherent risks to patients. These risks include pain, nausea and vomiting, laryngeal damage, anaphylaxis to anesthetic agents, cardiovascular collapse, respiratory depression, and dizziness. We must ensure that all anesthesia providers are safe to practice and are equipped with the skills to respond to medical emergencies. The administration of anesthesia is safe because of the skillset and training of the provider, their ability to immediately intervene to maintain patient stability, and continuously evaluate the interventions to maintain patient safety. A "simple anesthetic" does not exist.

AA education and training does not ensure the critical thinking skills necessary to respond to immediate patient emergencies. For example, there is no requirement for AAs to have any patient care experience prior to beginning their training. AAs do not have a broad foundation to reference when a patient's condition deteriorates. When life and death decisions are required, the operating surgeon will be forced to step in until the anesthesiologist, who is caring for other patients under anesthesia throughout a hospital, becomes available. This situation places the patient at immense risk at their most vulnerable of moments. Results will negatively impact the patient, provider, surgeon, and hospital.

Citizens of Washington State deserve proven, safe providers. The quality of care that AAs provide remains unknown; no meaningful research data exists concerning AA anesthesia quality and safety. The anesthesia care team model, which their supervision is mandated, is inefficient, costly, and concerning their lack of experience, would leave patients vulnerable. In contrast, the excellent, safe anesthesia care that CRNAs offer with associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.

Washington state must support its existing, high quality anesthesia providers, CRNAs and physician anesthesiologists. Licensure for a narrowly trained provider with limited usefulness will not be beneficial in many healthcare settings, especially during our current COVID crisis. CRNAs are prepared to be instrumental in providing access to quality care while decreasing healthcare costs. CRNAs have consistently expanded their roles and services to help cover gaps in care during the COVID pandemic. Please reject licensure for anesthesiologist assistants.

Sincerely, Kelli Camp, MSN, CRNA

I am a Certified Registered Nurse Anesthetist (CRNA) and member of Washington's Association of Nurse Anesthetists. I was appalled to see the Department of Health's recommendation of anesthesiology assistant (AA) licensure in its sunrise report.

While most anesthesia providers are trained in minimizing the risk of anesthesia, some of those risks can potentially carry huge consequences to one's health. That is why it is of the utmost importance anesthesia providers have the skills and knowledge to intervene and protect their patients.

AA training and education does not provide the essential skills involved with managing critical patient emergencies. AA education is lacking requirements of a 4-year degree in science or previous experience in patient care. This is a crucial requirement that helps build the foundation of recognizing critical illness or deterioration in a patient's health. The AA's overseeing anesthesiologist frequently is caring for other patients throughout the hospital. When immediate life and death decisions are required, the operating surgeon will be forced to step in until the anesthesiologist becomes available. During these critical moments this situation places the patient at a huge risk. Results will negatively impact the patient, provider, surgeon, and hospital.

This anesthesia care team model with mandated supervision is inefficient, expensive and the quality of care is unknown. I am unaware of any data addressing AA quality of anesthesia care and safety. The safe anesthesia care CRNAs provide has been proven time and time again in multiple published peer reviewed studies. Washington State's citizens warrant safe anesthesia care delivered by proven safe anesthesia providers.

Washington state already has existing, high quality anesthesia providers, CRNAs and physician anesthesiologists. Licensure for a narrowly trained provider with limited usefulness will not be beneficial in many healthcare settings, especially during our current COVID crisis. CRNAs are prepared to be instrumental in providing access to quality care while decreasing healthcare costs. I ask you to please reject licensure for anesthesiologist assistants.

Sincerely, Annemieke Hiemstra

As a certified registered nurse anesthetist (CRNA) and a member of the American Association of Nurse Anesthetists (AANA), I am extremely disappointed that the Department of Health is

recommending anesthesiologist assistant licensure in its draft sunrise report. The public will not be protected by licensing anesthesiologist assistants (AAs). I urge you to change your recommendation and reject licensure of AAs. For the viewpoint of Washington taxpayers, what is the cost to fund another licensing board and maintain the AAs license. Because anyone who provides anesthesia should be held to the same regulatory standards as CRNA or anesthesiologists. They should practice under their own licenses and not under the delegated authority of another practitioner.

The administration of anesthesia, including general anesthesia, has inherent risks to patients. These risks include pain, nausea and vomiting, laryngeal damage, anaphylaxis to anesthetic agents, cardiovascular collapse, respiratory depression, and dizziness. We must ensure that all anesthesia providers are safe to practice and are equipped with the skills to respond to medical emergencies. The administration of anesthesia is safe because of the skillset and training of the provider, their ability to immediately intervene to maintain patient stability, and continuously evaluate the interventions to maintain patient safety. A "simple anesthetic" does not exist. AA education and training does not ensure the critical thinking skills necessary to respond to immediate patient emergencies. For example, there is no requirement for AAs to have any patient care experience prior to beginning their training. AAs do not have a broad foundation to reference when a patient's condition deteriorates. When life and death decisions are required, the operating surgeon will be forced to step in until the anesthesiologist, who is caring for other patients under anesthesia throughout a hospital, becomes available. This situation places the patient at immense risk at their most vulnerable of moments. Results will negatively impact the patient, provider, surgeon, and hospital. Citizens of Washington State deserve proven, safe providers. The quality of care that AAs provide remains unknown; no meaningful research data exists concerning AA anesthesia quality and safety. The anesthesia care team model, which their supervision is mandated, is inefficient, costly, and concerning their lack of experience, would leave patients vulnerable. In contrast, the excellent, safe anesthesia care that CRNAs offer with associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.

Washington state must support its existing, high quality anesthesia providers, CRNAs and physician anesthesiologists. Licensure for a narrowly trained provider with limited usefulness will not be beneficial in many healthcare settings, especially during our current COVID crisis. CRNAs are prepared to be instrumental in providing access to quality care while decreasing healthcare costs. Please reject licensure for anesthesiologist assistants.

Sincerely, Christine A Salvator, CRNA MSN APRN

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I am extremely concerned that the Department of Health (DOH) is recommending anesthesiologist assistant (AA) licensure in its draft sunrise report. The public will not be protected, but instead put at greater risk by licensing anesthesiologist assistants (AAs). I urge you to change your recommendation and reject the licensure of AAs.

The administration of anesthesia, including general anesthesia, has inherent risks to patients. These risks include pain, nausea and vomiting, laryngeal damage, anaphylaxis to anesthetic agents, cardiovascular collapse, respiratory depression, and dizziness. The Department of Health must ensure that all anesthesia providers are safe to practice and are equipped with the extremely important skills to respond to medical emergencies not only during surgery but when patients come in as traumas and when patients code on the floor. The current administration of anesthesia remains safe because of the skills and extent of training of the providers, their ability to immediately intervene to maintain patient stability, and continuously evaluate the interventions to maintain patient safety.

AA education and training does NOT ensure the critical thinking skills necessary to respond to immediate patient emergencies. For example, there is no requirement for AAs to have any patient care experience prior AT ALL to be accepted to an AA program and begin their training. AAs do not have a broad foundation/critical care background to reference when a patient's condition deteriorates. When life and death decisions are required, the surgeon performing the procedure will be forced to step in until the anesthesiologist, who is caring for other patients under anesthesia throughout a hospital, becomes available. This situation places the patient at immense risk at their most vulnerable moments. Detrimental outcomes that will negatively impact the patient, provider, surgeon, and hospital. This is a stark contrast to how CRNAs can provide impeccable care in these situations to their background in critical care as well as their superior training in independently providing anesthesia.

The citizens of Washington State deserve safe, proven providers. The quality of care that AAs provide remains unknown. No meaningful research data exists concerning AA anesthesia and quality and safety outcomes. The anesthesia care team model, which is the only anesthesia model AAs are able to practice under, is inefficient, costly, and leaves patients vulnerable due to their lack of training.

In contrast, the proven, excellent anesthesia care that CRNAs offer with safe anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals. Washington state MUST continue to support its existing, high quality anesthesia providers: CRNAs and physician anesthesiologists. Licensure for a narrowly trained provider with limited usefulness will not be beneficial in many healthcare settings, especially during our current COVID crisis. Currently, with a complete halt of all non-emergent surgical cases, we as CRNAs have offered our skillset as prior critical care ICU RNs to assist with the COVID surge in the ICUs as well as providing our advance skill set in anesthesia as an ARNP CRNA for assistance to the MD/ARNP critical care providers. AAs simply cannot provide this cross over care as we can, nor do they even remotely have any set of background or credentials to provide these skills nor credentials as a sole provider and would prove useless in this situation. CRNAs are prepared to be instrumental in providing access to quality care while decreasing healthcare costs and have truly stepped up to help the burden of the crisis care that is occurring across WA.

Thank you for your consideration in this matter.

Again, I humbly urge you to reject licensure for anesthesiologist assistants in the state of Washington.

Respectfully, Dr. Jessie Bozelka, DNP, CRNA

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I am extremely disappointed that the Department of Health is recommending anesthesiologist assistant licensure in its draft sunrise report. The public will not be protected by licensing anesthesiologist assistants (AAs). I urge you to change your recommendation and reject licensure of AAs.

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condition deteriorates. When life and death decisions are required, the operating surgeon will be forced to step in until the anesthesiologist, who is caring for other patients under anesthesia throughout a hospital, becomes available. This situation places the patient at immense risk at their most vulnerable of moments. Results will negatively impact the patient, provider, surgeon, and hospital.

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Washington state must support its existing, high quality anesthesia providers, CRNAs and physician anesthesiologists. Licensure for a narrowly trained provider with limited usefulness will not be beneficial in many healthcare settings, especially during our current COVID crisis. CRNAs are prepared to be instrumental in providing access to quality care while decreasing healthcare costs. Please reject licensure for anesthesiologist assistants.

Sincerely, Patrick Brown, DNAP, CRNA

As a certified registered nurse anesthetist (CRNA) and soon to be member of the Washington Association of Nurse Anesthetists (WANA), I am extremely disappointed that the Department of Health is recommending anesthesiologist assistant licensure in its draft sunrise report. The public will not be protected by licensing anesthesiologist assistants (AAs). I urge you to change your recommendation and reject licensure of AAs.

As a CRNA looking to move to Washington State along with my husband who bros his engineering skills we are seriously considering not moving to the state based on the current proposed AA platform.

I currently practice in California as an autonomous provider who provides rural access care to patients who need anesthesia. Bringing in AAs will not only discourage excellent anesthesia talent to the state you put your Siri end at risk for subpar care.

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Citizens of Washington State deserve proven, safe providers. The quality of care that AAs provide remains unknown; no meaningful research data exists concerning AA anesthesia quality and safety. The anesthesia care team model, which their supervision is mandated, is inefficient, costly, and concerning

their lack of experience, would leave patients vulnerable. In contrast, the excellent, safe anesthesia care that CRNAs offer with associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.

Washington state must support its existing, high quality anesthesia providers, CRNAs and physician anesthesiologists. Licensure for a narrowly trained provider with limited usefulness will not be beneficial in many healthcare settings, especially during our current COVID crisis. CRNAs are prepared to be instrumental in providing access to quality care while decreasing healthcare costs.

Best, Laura Gal, CRNA, MSN

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Sincerely, Shamim Ghadami, CRNA, MS, ARNP

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I am extremely disappointed that the Department of Health is recommending anesthesiologist assistant licensure in its draft sunrise report. The public will not be protected by licensing anesthesiologist assistants (AAs). I urge you to change your recommendation and reject licensure of AAs.

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Prior to my training as a CRNA, I worked as an RN in Oregon for over 10 years, working in critical care, cardiovascular labs, and originally as a floor nurse. The experience gained as an RN is incredibly important and beneficial to a CRNA on a daily basis, and its importance must not be trivialized. The skills gained during a nursing career are broad and varied. These skills range from the ability to manage a decompensating patient while maintaining one's composure and continuing to communicate with a team, or just being able to recognize when a patient is apprehensive or fearful of an upcoming surgery.
Washington state must support its existing, high quality anesthesia providers, CRNAs and physician anesthesiologists. Licensure for a narrowly trained provider with limited usefulness will not be beneficial in many healthcare settings, especially during our current COVID crisis. CRNAs are prepared to be instrumental in providing access to quality care while decreasing healthcare costs. Please reject licensure for anesthesiologist assistants.

Thank you kindly for your time, I hope you will consider my recommendations,

Ananth Thitte, RN, BSN, MSNA, CRNA

I am an CRNA who left my home state of Texas and moved across the country when AAs started being introduced to our anesthesia team in Austin, Texas. I did not feel it was safe working with them. Many others of my coworkers left as well and moved to other parts of the country. Licensing AAs will not help the staffing problem. The job I left now has a rotating door of staff.
As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I am extremely disappointed that the Department of Health is recommending anesthesiologist assistant licensure in its draft sunrise report. The public will not be protected by licensing anesthesiologist assistants (AAs). I urge you to change your recommendation and reject licensure of AAs.
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Washington state must support its existing, high quality anesthesia providers, CRNAs and physician anesthesiologists. Licensure for a narrowly trained provider with limited usefulness will not be beneficial in many healthcare settings, especially during our current COVID crisis. CRNAs are prepared to be instrumental in providing access to quality care while decreasing healthcare costs. Please reject licensure for anesthesiologist assistants.

Thank you, Tania Derington, CRNA

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I am extremely disappointed that the Department of Health is recommending anesthesiologist assistant licensure in its draft sunrise report. The public will not be protected by licensing anesthesiologist assistants (AAs). **I urge you to change your recommendation and reject licensure of AAs.**

As a mentor often said, "there are no small or simple anesthetics, only small surgeries." We must ensure that all anesthesia
providers are safe to practice and are equipped with the skills to respond to medical emergencies. The administration of anesthesia is safe because of the skillset and training of the provider, their ability to immediately intervene to maintain patient stability, and continuously evaluate the interventions to maintain patient safety.

AA education and training does not ensure the critical thinking skills necessary to respond to immediate patient emergencies. For example, there is no requirement for AAs to have any patient care experience prior to beginning their training. **Furthermore, as stated in the sunrise review information packet, AA training is only two years of graduate work at the Master's level. CRNAs today are prepared via at least a three year doctoral program after bachelor's undergraduate degrees in nursing, obtaining critical care experience and achieving critical care certification.**

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to reference when a patient's condition deteriorates. When life and death decisions are required, the operating surgeon will be forced to step in until the anesthesiologist, who is caring for other patients under anesthesia throughout a hospital, becomes available. This situation places the patient at immense risk at their most vulnerable moments. Results will negatively impact the patient, provider, surgeon, and hospital. **Citizens of Washington State deserve proven, safe providers.** The quality of care that AAs
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Washington state must support its existing, high quality anesthesia providers, CRNAs and physician

anesthesiologists. **Licensure for a narrowly trained provider with limited usefulness will not be beneficial in many healthcare settings, especially during our current COVID crisis.** CRNAs are prepared to be instrumental in providing access to quality care while decreasing healthcare costs. **Why legislate into existence a provider type requiring two people to do the work of one?** Please reject licensure for anesthesiologist assistants.

Sincerely, Gregory Clopp, MSN, CRNA/APRN

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I am appalled that the Department of Health (DOH) is recommending anesthesiologist assistant (AA) licensure in its draft sunrise report. The public will not be protected by licensing anesthesiologist assistants (AAs). I urge you to change your recommendation and reject the licensure of AAs!

The administration of anesthesia, including general anesthesia, has inherent risks to patients. These risks include pain, nausea and vomiting, laryngeal damage, anaphylaxis to anesthetic agents, cardiovascular collapse, respiratory depression, and dizziness. We MUST ensure that all anesthesia providers are safe to practice and are equipped with the skills to respond to medical emergencies. The administration of anesthesia is safe because of the skillset and training of the provider, their ability to immediately intervene to maintain patient stability, and continuously evaluate the interventions to maintain patient safety. A “simple anesthetic” does NOT exist.

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Please reject licensure for anesthesiologist assistants.

Sincerely, Dana M. Brown, MSNA, CRNA

Hello, I will share my experience working with AAs in Missouri. I have found the majority of AAs lack the knowledge and experience to provide safe anesthesia. They are 100% reliant on the anesthesiologists for every anesthetic given and are unsafe in emergency situations. Every anesthetic I give is different and requires fast retrieval of my knowledge and skillset to actively adjust to the patient's needs. AAs do not have the adequate training to do this well. I have spent years as an RN, gaining experience before I even entered Anesthesia school. Our training is intensive in all disciplines of anesthesia, pharmacology, physiology, chemistry, physics and research. This is a power grab by anesthesiologists to remain relevant in our current healthcare system. Anesthesiologists are high costs to hospitals and research shows they do not give better or safer anesthesia compared to CRNAs. We have been proven over and over to give cost efficient and very safe anesthesia. Our patient care is renowned.

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I am extremely disappointed that the Department of Health is recommending anesthesiologist assistant licensure in its draft sunrise report. The public will not be protected by licensing anesthesiologist assistants (AAs). I urge you to change your recommendation and reject licensure of AAs.

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Sincerely, (not signed)

Interesting that the third criterion was decided as "not applicable". The DOH will have to defend this in the future when we demonstrate increasing costs to the public.

The public could be effectively protected by "other, more cost-beneficial means", meaning, the option to *not allow* anesthesiologist assistants to practice in Washington. By allowing licensure for AA's to practice in Washington, you will be increasing the costs to the Washington tax paying public, both by adminstrative costs of regulating an entirely new profession at DOH, and increased costs of hospital and procedural care to patients.

Here, the public could be protected by "other, more cost-beneficial means", by denying licensure of a profession that will inevitably increase anesthesia costs to patients, and bureaucratic costs to taxpayers in general. I don't know what the cost increase will be to regulate a new profession, but many tax payers are fed up with increasing bureaucratic costs in WA.

I previously asked to consider the math when analyzing costs to patients. Both: 1/4 anesthesiologist (300k/year)+ 1 anesthesiologist assistant(170k/year), 24 hours a day 7 days a week. Or (chose one) anesthesiologist(300k/year) -or- CRNA (190k/year) 24/7. Obviously, the public CAN be protected by more cost-beneficial means by not trying to fix something that was not broken to begin with. The only thing WSSA will tell you that is broken are their attempts to control anesthesia by refusing to hire CRNAs.

Also, when reviewing the patient safety language:

"Clarify the definition of supervision to require the supervising anesthesiologist to be present in the operating suite, office, obstetrical unit, or other setting; and present in the operating room during induction of general or regional anesthesia or emergence from general anesthesia."

"Supervised" anesthesia services by anesthesiologists can occur when an anesthesiologist is involved in 5 OR MORE concurrent anesthesia procedures. Medical supervision also occurs when the seven required services under medical direction are not performed by the anesthesiologist. This can occur in cases where the anesthesiologist was not otherwise available to respond to the immediate needs of the surgical patient. "Supervision" should be replaced with "Direction" in your language regarding AAs. CRNAS can practice independently, supervised, or directed.

This would require changing all your language to fit <u>direction</u> criteria, which is the only way AAs practice. For example the previous paragraph should replace "supervision" with "direction" and:

"regional anesthesia ***<u>AND</u>*** emergence from general anesthesia."

Under <u>direction</u>, an anesthesiologist is required to be present for the 7 required cms services. (1. preop, 2. prescription of anesthesia plan, 3. participating in most demanding procedures of anesthesia such as induction and emergence, 4. delegating anesthesia care, 5. frequent actual presence in room to monitor course of anesthesia, 6. <u>physically present for all key portions</u>, 7. post op care) This is where one commenter suggested up to 75% of cases are incorrectly billed. I personally have witnessed this number much higher in directed 1:4 ratios where in excess of 90% of cases never had an anesthesiologist physically present at emergence. I have been told this is possible medicare fraud. Allowing licensing of AAs under supervision is against the scope of AA practice, and nearly impossible to comply with.

Although "the department" recommends in favor of the proposal, I would highly recommend "the department" better familiarize itself with the differences between supervision and direction and the 7

criteria for DIRECTION of AAs.

Medicare: AAs are paid on the same basis as CRNAs, except that AA services must be billed as **medically directed**

Thank you for your time,

Zach Morgan, CRNA

As a patient, I am disappointed in the Department of Health's (DOH) preliminary decision to approve the licensure of anesthesiologist assistants (AAs). I urge you to reconsider this decision and reject this sunrise review application.
I am not a health care provider, but I am a health care consumer. I rely on DOH to ensure that any health care provider that is licensed is safe to practice. I do not have the tools to do this myself, especially for such a specialized practice as anesthesia. DOH has determined that anesthesiologists and Certified Registered Nurse Anesthetists (CRNAs) have rigorous education and training requirements and have an incredible amount of evidence to support their safety as a health care provider.
However, for anesthesiologist assistants, DOH has not shown enough evidence to conclude that AAs are safe to practice. The DOH sunrise report cites only the lack of disciplinary cases in other states as the sole reason AAs are safe. That's not enough for me. Until there is clear evidence that AAs are safe, DOH should reject AA licensure.

Sincerely, Deanna Melnik

As a patient, I am disappointed in the Department of Health's (DOH) preliminary decision to approve the licensure of anesthesiologist assistants (AAs). I urge you to reconsider this decision and reject this sunrise review application.
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Sincerely, Max Melnik

As a member and healthcare consumer in the State of Washington, I am disappointed in the Department of Health's (DOH) preliminary decision to approve the licensure of anesthesiologist assistants (AAs). I am writing to request that you reconsider this decision and reject this sunrise review application. DOH has determined that anesthesiologists and Certified Registered Nurse Anesthetists (CRNAs) have rigorous education and training requirements and have an incredible amount of evidence to support their safety as a health care provider. I expect the DOH to ensure that any health care provider that is licensed is safe to practice. I do not have the tools to do this myself, especially for such a specialized practice as anesthesia. However, for anesthesiologist assistants, DOH has not shown enough evidence to conclude that AAs are safe to practice. The DOH sunrise report cites only the lack of

disciplinary cases in other states as the sole reason AAs are safe. That is insufficient, inappropriate and unacceptable to me. Until there is clear evidence that AAs are safe, DOH should reject AA licensure.

Sincerely, Stephen Uffens

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Sincerely, Carissa Bowman

As a patient, I am disappointed in the Department of Health's (DOH) preliminary decision to approve the licensure of anesthesiologist assistants (AAs). I urge you to reconsider this decision and reject this sunrise review application.
I am not a health care provider, but I am a health care consumer. I rely on DOH to ensure that any health care provider that is licensed is safe to practice. I do not have the tools to do this myself, especially for such a specialized practice as anesthesia. DOH has determined that anesthesiologists and Certified Registered Nurse Anesthetists (CRNAs) have rigorous education and training requirements and have an incredible amount of evidence to support their safety as a health care provider.
However, for anesthesiologist assistants, DOH has not shown enough evidence to conclude that AAs are safe to practice. The DOH sunrise report cites only the lack of disciplinary cases in other states as the sole reason AAs are safe. That's not enough for me. Until there is clear evidence that AAs are safe, DOH should reject AA licensure.

Sincerely, Sarah Korkowski

As a patient, I am disappointed in the Department of Health's (DOH) preliminary decision to approve the licensure of anesthesiologist assistants (AAs). I urge you to reconsider this decision and reject this sunrise review application.

I am not a health care provider, but I am a health care consumer. I rely on DOH to ensure that any health care provider that is licensed is safe to practice. I do not have the tools to do this myself, especially for such a specialized practice as anesthesia. DOH has determined that anesthesiologists and Certified Registered Nurse Anesthetists (CRNAs) have rigorous education and training requirements and have an incredible amount of evidence to support their safety as a health care provider.

However, for anesthesiologist assistants, DOH has not shown enough evidence to conclude that

AAs are safe to practice. The DOH sunrise eport cites only the lack of disciplinary cases in other states as the sole reason AAs are safe. That's not enough for me. Until there is clear evidence that AAs are safe, DOH should reject AA licensure.

Sincerely, Tricia Clemans

As a patient, I am disappointed in the Department of Health's (DOH) preliminary decision to approve the licensure of anesthesiologist assistants (AAs). I urge you to reconsider this decision and reject this sunrise review application.
I am not a health care provider, but I am a health care consumer. I rely on DOH to ensure that any health care provider that is licensed is safe to practice. I do not have the tools to do this myself, especially for such a specialized practice as anesthesia. DOH has determined that anesthesiologists and Certified Registered Nurse Anesthetists (CRNAs) have rigorous education and training requirements and have an incredible amount of evidence to support their safety as a health care provider.
However, for anesthesiologist assistants, DOH has not shown enough evidence to conclude that AAs are safe to practice. The DOH sunrise eport cites only the lack of disciplinary cases in other states as the sole reason AAs are safe. That's not enough for me. Until there is clear evidence, I request that the DOH rejects the licensure of AAs in Washington State.

Respectfully, JOHN ANDERSON

As a patient, I am disappointed in the Department of Health's (DOH) preliminary decision to approve the licensure of anesthesiologist assistants (AAs). I urge you to reconsider this decision and reject this sunrise review application, as **AAs do not have the qualifications or evidence-based track record to safely provide anesthesia**.

I am not a health care provider, but I am a health care consumer. I rely on DOH to ensure that any health care provider that is licensed is safe to practice. I do not have the tools to do this myself, especially for such a specialized practice as anesthesia. DOH has determined that anesthesiologists and Certified Registered Nurse Anesthetists (CRNAs) have rigorous education and training requirements and have an incredible amount of evidence to support their safety as a health care provider.

AAs would leave patients like me vulnerable under anesthesia, as they rely on a physician anesthesiologist to make critical decisions. Often the physician anesthesiologist has many other duties at a given moment, rendering patients like me in danger.

However, for anesthesiologist assistants, DOH has not shown enough evidence to conclude that AAs are safe to practice. The DOH sunrise report cites only the lack of disciplinary cases in other states as the sole reason AAs are safe. That's not enough for me. **Until there is clear evidence that AAs are safe, I am not comfortable having surgery in Washington**.

Sincerely, Evan C. Schafer

As a patient, I am disappointed in the Department of Health's (DOH) preliminary decision to approve the licensure of anesthesiologist assistants (AAs). I urge you to reconsider this decision and reject this sunrise review application.

I am not a health care provider, but I am a health care consumer. I rely on DOH to ensure that any health care provider that is licensed is safe to practice. I do not have the tools to do this myself, especially for such a specialized practice as anesthesia. DOH has determined that anesthesiologists and Certified Registered Nurse Anesthetists (CRNAs) have rigorous education and training requirements and have an incredible amount of evidence to support their safety as a health care provider.

However, for anesthesiologist assistants, DOH has not shown enough evidence to conclude that AAs are safe to practice. The DOH sunrise eport cites only the lack of disciplinary cases in other states as the sole reason AAs are safe. That's not enough for me. Until there is clear evidence that AAs are safe, DOH should reject AA licensure.

Sincerely, Jeudiel Puente

As a resident of Washington state, I am disappointed in the Department of Health's (DOH) preliminary decision to approve the licensure of anesthesiologist assistants (AAs). I strongly urge you to reconsider this decision and reject this sunrise review application.
I am not a health care provider, but I am a health care consumer. I rely on DOH to ensure that the residents of Washington are cared for by qualified providers. DOH has determined that anesthesiologists and Certified Registered Nurse Anesthetists (CRNAs) have rigorous education and training requirements and have an incredible amount of evidence to support their safety as a health care provider.

However, for anesthesiologist assistants, DOH has not shown enough evidence to conclude that AAs are safe to practice. The DOH sunrise report cites only the lack of disciplinary cases in other states as the sole reason AAs are safe. That's not enough for me. I do not want to subject myself or my loved ones to this experiment. Until there is clear evidence that AAs are safe, DOH should reject AA licensure.

Sincerely, Dmitriy Nekhamis

As an anesthesiologist and Washington State citizen, I am writing to thank you for your draft Report to the Legislature finding in favor of the proposal to license certified anesthesiologist assistants (CAAs) in our state and to urge you to continue this favorable support in your final report. Currently, anesthesiologists have only one option for a non-physician anesthesia provider – authorizing CAAs to practice here would expand that option to include an additional provider. Moreover, it would bring additional qualified mid-level providers to our state, and importantly, would provide our patients with access to the benefits CAAs already provide to nearly 20 other jurisdictions. CAAs are highly trained master's degree level non-physician anesthesia care providers. They work under the medical direction of anesthesiologists to implement anesthesia care plans. CAAs work exclusively within the Anesthesia Care Team environment as described by ASA. The Anesthesia Care Team consists of a supervising anesthesiologist and from 1 to 4 non-physician anesthesia providers (i.e., CAAs, nurse anesthetists, or anesthesiology physician residents/fellows). All CAAs possess a premedical undergraduate background and complete a comprehensive didactic and clinical program at the graduate school master's degree level. They are trained extensively in the delivery and maintenance of quality anesthesia care as well as advanced patient monitoring techniques. Hospitals and related institutions seeking to utilize the Anesthesia Care Team approach to patient care should be authorized to do so with any qualified anesthesia provider under physician-led care and NOT be deprived the choice of qualified, medically-based trained CAAs. CAAs undergo rigorous and advanced graduate education in accredited master's degree programs ranging from 24 to 28 months, focusing on the Anesthesia Care Team approach to anesthesia practice. As a pre-requisite for admissions, applicants must hold a bachelor's degree, complete the same pre-medical course work that physicians complete, and score competitively in upper percentiles on the MCAT (Medical College Admission Test). CAAs are as safe and effective as nurse anesthetists and there is peer-reviewed, credible evidence to support this position. A 2018 study published in the peer-reviewed journal Anesthesiology confirmed the safety and efficacy of CAAs when it examined care between an anesthesiologist – nurse anesthetist team and an anesthesiologist – anesthesiologist assistant team. The results found "the specific composition of the anesthesia care team was not associated with any significant differences in mortality, length of stay, or inpatient spending." My anesthesiologist colleagues who work with both CAAs and nurse anesthetists can attest to the complete interchangeability of the two types of non-physician anesthesia providers. CAAs and nurse anesthetists have identical patient care responsibilities and technical capabilities – a view in harmony with their equivalent treatment under the Medicare Program. I want to thank you for your initial draft finding in favor of licensing CAAs in Washington State and strongly urge you to continue to support this position as you draft the final report, for the reasons highlighted above. Thank you for your consideration.

Sincerely, Dr. Jeffry P Minard MD

As an anesthesiologist and Washington State citizen, I am writing to thank you for your draft Report to the Legislature finding in favor of the proposal to license certified anesthesiologist assistants (CAAs) in our state and to urge you to continue this favorable support in your final report. Currently, anesthesiologists have only one option for a non-physician anesthesia provider – authorizing CAAs to practice here would expand that option to include an additional provider. Moreover, it would bring additional qualified mid-level providers to our state, and importantly, would provide our patients with access to the benefits CAAs already provide to nearly 20 other jurisdictions. CAAs are highly trained master's degree level non-physician anesthesia care providers. They work under the medical direction of anesthesiologists to implement anesthesia care plans. CAAs work exclusively within the Anesthesia Care Team environment as described by ASA. The Anesthesia Care Team consists of a supervising anesthesiologist and from 1 to 4 non-physician anesthesia providers (i.e., CAAs, nurse anesthetists, or anesthesiology physician residents/fellows). All CAAs possess a premedical undergraduate background and complete a comprehensive didactic and clinical program at the graduate school master's degree level. They are trained extensively in the delivery and maintenance of quality anesthesia care as well as

advanced patient monitoring techniques. Hospitals and related institutions seeking to utilize the Anesthesia Care Team approach to patient care should be authorized to do so with any qualified anesthesia provider under physician-led care and NOT be deprived the choice of qualified, medically-based trained CAAs. CAAs undergo rigorous and advanced graduate education in accredited master's degree programs ranging from 24 to 28 months, focusing on the Anesthesia Care Team approach to anesthesia practice. As a pre-requisite for admissions, applicants must hold a bachelor's degree, complete the same pre-medical course work that physicians complete, and score competitively in upper percentiles on the MCAT (Medical College Admission Test). CAAs are as safe and effective as nurse anesthetists and there is peer-reviewed, credible evidence to support this position. A 2018 study published in the peer-reviewed journal Anesthesiology confirmed the safety and efficacy of CAAs when it examined care between an anesthesiologist – nurse anesthetist team and an anesthesiologist – anesthesiologist assistant team. The results found "the specific composition of the anesthesia care team was not associated with any significant differences in mortality, length of stay, or inpatient spending." My anesthesiologist colleagues who work with both CAAs and nurse anesthetists can attest to the complete interchangeability of the two types of non-physician anesthesia providers. CAAs and nurse anesthetists have identical patient care responsibilities and technical capabilities – a view in harmony with their equivalent treatment under the Medicare Program. I want to thank you for your initial draft finding in favor of licensing CAAs in Washington State and strongly urge you to continue to support this position as you draft the final report, for the reasons highlighted above. Thank you for your consideration.

Sincerely,

Dr. Christopher M. Savage M.D.

As an anesthesiologist and Washington State citizen, I am writing to thank you for your draft Report to the Legislature finding in favor of the proposal to license certified anesthesiologist assistants (CAAs) in our state and to urge you to continue this favorable support in your final report. Currently, anesthesiologists have only one option for a non-physician anesthesia provider – authorizing CAAs to practice here would expand that option to include an additional provider. Moreover, it would bring additional qualified mid-level providers to our state, and importantly, would provide our patients with access to the benefits CAAs already provide to nearly 20 other jurisdictions. CAAs are highly trained master's degree level non-physician anesthesia care providers. They work under the medical direction of anesthesiologists to implement anesthesia care plans. CAAs work exclusively within the Anesthesia Care Team environment as described by ASA. The Anesthesia Care Team consists of a supervising anesthesiologist and from 1 to 4 non-physician anesthesia providers (i.e., CAAs, nurse anesthetists, or anesthesiology physician residents/fellows). All CAAs possess a premedical undergraduate background and complete a comprehensive didactic and clinical program at the graduate school master's degree level. They are trained extensively in the delivery and maintenance of quality anesthesia care as well as advanced patient monitoring techniques. Hospitals and related institutions seeking to utilize the Anesthesia Care Team approach to patient care should be authorized to do so with any qualified anesthesia provider under physician-led care and NOT be deprived the choice of qualified, medically-based trained CAAs. CAAs undergo rigorous and advanced graduate education in accredited master's degree programs ranging from 24 to 28 months, focusing on the Anesthesia Care Team approach to anesthesia practice. As a pre-requisite for admissions, applicants must hold a bachelor's degree, complete the same pre-medical course work that physicians complete, and score competitively in upper percentiles on the MCAT (Medical College Admission Test). CAAs are as safe and effective as nurse anesthetists and there is peer-reviewed, credible evidence to support this position. A 2018 study published in the peer-reviewed journal Anesthesiology confirmed the safety and efficacy of CAAs when

it examined care between an anesthesiologist – nurse anesthetist team and an anesthesiologist – anesthesiologist assistant team. The results found “the specific composition of the anesthesia care team was not associated with any significant differences in mortality, length of stay, or inpatient spending.” My anesthesiologist colleagues who work with both CAAs and nurse anesthetists can attest to the complete interchangeability of the two types of non-physician anesthesia providers. CAAs and nurse anesthetists have identical patient care responsibilities and technical capabilities – a view in harmony with their equivalent treatment under the Medicare Program. I want to thank you for your initial draft finding in favor of licensing CAAs in Washington State and strongly urge you to continue to support this position as you draft the final report, for the reasons highlighted above. Thank you for your consideration.

Sincerely, Dr. Julie S. Vath M.D.

As an anesthesiologist and Washington State citizen, I am writing to thank you for your draft Report to the Legislature finding in favor of the proposal to license certified anesthesiologist assistants (CAAs) in our state and to urge you to continue this favorable support in your final report. Currently, anesthesiologists have only one option for a non-physician anesthesia provider – authorizing CAAs to practice here would expand that option to include an additional provider. Moreover, it would bring additional qualified mid-level providers to our state, and importantly, would provide our patients with access to the benefits CAAs already provide to nearly 20 other jurisdictions. CAAs are highly trained master’s degree level non-physician anesthesia care providers. They work under the medical direction of anesthesiologists to implement anesthesia care plans. CAAs work exclusively within the Anesthesia Care Team environment as described by ASA. The Anesthesia Care Team consists of a supervising anesthesiologist and from 1 to 4 non-physician anesthesia providers (i.e., CAAs, nurse anesthetists, or anesthesiology physician residents/fellows). All CAAs possess a premedical undergraduate background and complete a comprehensive didactic and clinical program at the graduate school master’s degree level. They are trained extensively in the delivery and maintenance of quality anesthesia care as well as advanced patient monitoring techniques. Hospitals and related institutions seeking to utilize the Anesthesia Care Team approach to patient care should be authorized to do so with any qualified anesthesia provider under physician-led care and NOT be deprived the choice of qualified, medically-based trained CAAs. CAAs undergo rigorous and advanced graduate education in accredited master’s degree programs ranging from 24 to 28 months, focusing on the Anesthesia Care Team approach to anesthesia practice. As a pre-requisite for admissions, applicants must hold a bachelor’s degree, complete the same pre-medical course work that physicians complete, and score competitively in upper percentiles on the MCAT (Medical College Admission Test). CAAs are as safe and effective as nurse anesthetists and there is peer-reviewed, credible evidence to support this position. A 2018 study published in the peer-reviewed journal Anesthesiology confirmed the safety and efficacy of CAAs when it examined care between an anesthesiologist – nurse anesthetist team and an anesthesiologist – anesthesiologist assistant team. The results found “the specific composition of the anesthesia care team was not associated with any significant differences in mortality, length of stay, or inpatient spending.” My anesthesiologist colleagues who work with both CAAs and nurse anesthetists can attest to the complete interchangeability of the two types of non-physician anesthesia providers. CAAs and nurse anesthetists have identical patient care responsibilities and technical capabilities – a view in harmony with their equivalent treatment under the Medicare Program. I want to thank you for your initial draft finding in favor of licensing CAAs in Washington State and strongly urge you to continue to support this position as you draft the final report, for the reasons highlighted above. Thank you for your consideration.

Sincerely,

Dr. David A. Burns M.D.

As an anesthesiologist and Washington State citizen, I am writing to thank you for your draft Report to the Legislature finding in favor of the proposal to license certified anesthesiologist assistants (CAAs) in our state and to urge you to continue this favorable support in your final report. Currently, anesthesiologists have only one option for a non-physician anesthesia provider – authorizing CAAs to practice here would expand that option to include an additional provider. Moreover, it would bring additional qualified mid-level providers to our state, and importantly, would provide our patients with access to the benefits CAAs already provide to nearly 20 other jurisdictions. CAAs are highly trained master's degree level non-physician anesthesia care providers. They work under the medical direction of anesthesiologists to implement anesthesia care plans. CAAs work exclusively within the Anesthesia Care Team environment as described by ASA. The Anesthesia Care Team consists of a supervising anesthesiologist and from 1 to 4 non-physician anesthesia providers (i.e., CAAs, nurse anesthetists, or anesthesiology physician residents/fellows). All CAAs possess a premedical undergraduate background and complete a comprehensive didactic and clinical program at the graduate school master's degree level. They are trained extensively in the delivery and maintenance of quality anesthesia care as well as advanced patient monitoring techniques. Hospitals and related institutions seeking to utilize the Anesthesia Care Team approach to patient care should be authorized to do so with any qualified anesthesia provider under physician-led care and NOT be deprived the choice of qualified, medically-based trained CAAs. CAAs undergo rigorous and advanced graduate education in accredited master's degree programs ranging from 24 to 28 months, focusing on the Anesthesia Care Team approach to anesthesia practice. As a pre-requisite for admissions, applicants must hold a bachelor's degree, complete the same pre-medical course work that physicians complete, and score competitively in upper percentiles on the MCAT (Medical College Admission Test). CAAs are as safe and effective as nurse anesthetists and there is peer-reviewed, credible evidence to support this position. A 2018 study published in the peer-reviewed journal Anesthesiology confirmed the safety and efficacy of CAAs when it examined care between an anesthesiologist – nurse anesthetist team and an anesthesiologist – anesthesiologist assistant team. The results found "the specific composition of the anesthesia care team was not associated with any significant differences in mortality, length of stay, or inpatient spending." My anesthesiologist colleagues who work with both CAAs and nurse anesthetists can attest to the complete interchangeability of the two types of non-physician anesthesia providers. CAAs and nurse anesthetists have identical patient care responsibilities and technical capabilities – a view in harmony with their equivalent treatment under the Medicare Program. I want to thank you for your initial draft finding in favor of licensing CAAs in Washington State and strongly urge you to continue to support this position as you draft the final report, for the reasons highlighted above. Thank you for your consideration.

Sincerely,

Dr. Satvinder S. Dhesi MD

As an anesthesiologist and Washington State citizen, I am writing to thank you for your draft Report to the Legislature finding in favor of the proposal to license certified anesthesiologist assistants (CAAs) in our state and to urge you to continue this favorable support in your final report. Currently, anesthesiologists have only one option for a non-physician anesthesia provider – authorizing CAAs to practice here would expand that option to include an additional provider. Moreover, it would bring additional qualified mid-level providers to our state, and importantly, would provide our patients with access to the benefits CAAs already provide to nearly 20 other jurisdictions. CAAs are highly trained

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Sincerely,

Dr. Jeffrey Yang

As an anesthesiologist and Washington State citizen, I am writing to thank you for your draft Report to the Legislature finding in favor of the proposal to license certified anesthesiologist assistants (CAAs) in our state and to urge you to continue this favorable support in your final report. Currently, anesthesiologists have only one option for a non-physician anesthesia provider – authorizing CAAs to practice here would expand that option to include an additional provider. Moreover, it would bring additional qualified mid-level providers to our state, and importantly, would provide our patients with access to the benefits CAAs already provide to nearly 20 other jurisdictions. CAAs are highly trained master's degree level non-physician anesthesia care providers. They work under the medical direction of anesthesiologists to implement anesthesia care plans. CAAs work exclusively within the Anesthesia Care Team environment as described by ASA. The Anesthesia Care Team consists of a supervising anesthesiologist and from 1 to 4 non-physician anesthesia providers (i.e., CAAs, nurse anesthetists, or anesthesiology physician residents/fellows). All CAAs possess a premedical undergraduate background and complete a comprehensive didactic and clinical program at the graduate school master's degree level. They are trained extensively in the delivery and maintenance of quality anesthesia care as well as advanced patient monitoring techniques. Hospitals and related institutions seeking to utilize the Anesthesia Care Team approach to patient care should be authorized to do so with any qualified anesthesia provider under physician-led care and NOT be deprived the choice of qualified, medically-

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Sincerely,

Dr. Nate A Paulson

As an anesthesiologist and Washington State citizen, I am writing to thank you for your draft Report to the Legislature finding in favor of the proposal to license certified anesthesiologist assistants (CAAs) in our state and to urge you to continue this favorable support in your final report. Currently, anesthesiologists have only one option for a non-physician anesthesia provider – authorizing CAAs to practice here would expand that option to include an additional provider. Moreover, it would bring additional qualified mid-level providers to our state, and importantly, would provide our patients with access to the benefits CAAs already provide to nearly 20 other jurisdictions. CAAs are highly trained master's degree level non-physician anesthesia care providers. They work under the medical direction of anesthesiologists to implement anesthesia care plans. CAAs work exclusively within the Anesthesia Care Team environment as described by ASA. The Anesthesia Care Team consists of a supervising anesthesiologist and from 1 to 4 non-physician anesthesia providers (i.e., CAAs, nurse anesthetists, or anesthesiology physician residents/fellows). All CAAs possess a premedical undergraduate background and complete a comprehensive didactic and clinical program at the graduate school master's degree level. They are trained extensively in the delivery and maintenance of quality anesthesia care as well as advanced patient monitoring techniques. Hospitals and related institutions seeking to utilize the Anesthesia Care Team approach to patient care should be authorized to do so with any qualified anesthesia provider under physician-led care and NOT be deprived the choice of qualified, medically-based trained CAAs. CAAs undergo rigorous and advanced graduate education in accredited master's degree programs ranging from 24 to 28 months, focusing on the Anesthesia Care Team approach to anesthesia practice. As a pre-requisite for admissions, applicants must hold a bachelor's degree, complete the same pre-medical course work that physicians complete, and score competitively in upper percentiles on the MCAT (Medical College Admission Test). CAAs are as safe and effective as nurse anesthetists and there is peer-reviewed, credible evidence to support this position. A 2018 study published in the peer-reviewed journal Anesthesiology confirmed the safety and efficacy of CAAs when it examined care between an anesthesiologist – nurse anesthetist team and an anesthesiologist – anesthesiologist assistant team. The results found "the specific composition of the anesthesia care team was not associated with any significant differences in mortality, length of stay, or inpatient spending."

My anesthesiologist colleagues who work with both CAAs and nurse anesthetists can attest to the complete interchangeability of the two types of non-physician anesthesia providers. CAAs and nurse anesthetists have identical patient care responsibilities and technical capabilities – a view in harmony with their equivalent treatment under the Medicare Program. I want to thank you for your initial draft finding in favor of licensing CAAs in Washington State and strongly urge you to continue to support this position as you draft the final report, for the reasons highlighted above. Thank you for your consideration. Sincerely,

Dr. Donald Thornton M.D.

As a resident anesthesiologist and Washington State citizen, I am writing to thank you for your draft Report to the Legislature finding in favor of the proposal to license certified anesthesiologist assistants (CAAs) in our state and to urge you to continue this favorable support in your final report. Currently, anesthesiologists have only one option for a non-physician anesthesia provider – authorizing CAAs to practice here would expand that option to include an additional provider. Moreover, it would bring additional qualified mid-level providers to our state, and importantly, would provide our patients with access to the benefits CAAs already provide to nearly 20 other jurisdictions. CAAs are highly trained master's degree level non-physician anesthesia care providers. They work under the medical direction of anesthesiologists to implement anesthesia care plans. CAAs work exclusively within the Anesthesia Care Team environment as described by ASA. The Anesthesia Care Team consists of a supervising anesthesiologist and from 1 to 4 non-physician anesthesia providers (i.e., CAAs, nurse anesthetists, or anesthesiology physician residents/fellows). All CAAs possess a premedical undergraduate background and complete a comprehensive didactic and clinical program at the graduate school master's degree level. They are trained extensively in the delivery and maintenance of quality anesthesia care as well as advanced patient monitoring techniques. Hospitals and related institutions seeking to utilize the Anesthesia Care Team approach to patient care should be authorized to do so with any qualified anesthesia provider under physician-led care and NOT be deprived the choice of qualified, medically-based trained CAAs. CAAs undergo rigorous and advanced graduate education in accredited master's degree programs ranging from 24 to 28 months, focusing on the Anesthesia Care Team approach to anesthesia practice. As a pre-requisite for admissions, applicants must hold a bachelor's degree, complete the same pre-medical course work that physicians complete, and score competitively in upper percentiles on the MCAT (Medical College Admission Test). CAAs are as safe and effective as nurse anesthetists and there is peer-reviewed, credible evidence to support this position. A 2018 study published in the peer-reviewed journal Anesthesiology confirmed the safety and efficacy of CAAs when it examined care between an anesthesiologist – nurse anesthetist team and an anesthesiologist – anesthesiologist assistant team. The results found "the specific composition of the anesthesia care team was not associated with any significant differences in mortality, length of stay, or inpatient spending." My anesthesiologist colleagues who work with both CAAs and nurse anesthetists can attest to the complete interchangeability of the two types of non-physician anesthesia providers. CAAs and nurse anesthetists have identical patient care responsibilities and technical capabilities – a view in harmony with their equivalent treatment under the Medicare Program. I want to thank you for your initial draft finding in favor of licensing CAAs in Washington State and strongly urge you to continue to support this position as you draft the final report, for the reasons highlighted above. Thank you for your consideration.

Sincerely,

Sam Rackley

As an anesthesiologist and Washington State citizen, I am writing to thank you for your draft Report to the Legislature finding in favor of the proposal to license certified anesthesiologist assistants (CAAs) in our state and to urge you to continue this favorable support in your final report. Currently, anesthesiologists have only one option for a non-physician anesthesia provider – authorizing CAAs to practice here would expand that option to include an additional provider. Moreover, it would bring additional qualified mid-level providers to our state, and importantly, would provide our patients with access to the benefits CAAs already provide to nearly 20 other jurisdictions. CAAs are highly trained master's degree level non-physician anesthesia care providers. They work under the medical direction of anesthesiologists to implement anesthesia care plans. CAAs work exclusively within the Anesthesia Care Team environment as described by ASA. The Anesthesia Care Team consists of a supervising anesthesiologist and from 1 to 4 non-physician anesthesia providers (i.e., CAAs, nurse anesthetists, or anesthesiology physician residents/fellows). All CAAs possess a premedical undergraduate background and complete a comprehensive didactic and clinical program at the graduate school master's degree level. They are trained extensively in the delivery and maintenance of quality anesthesia care as well as advanced patient monitoring techniques. Hospitals and related institutions seeking to utilize the Anesthesia Care Team approach to patient care should be authorized to do so with any qualified anesthesia provider under physician-led care and NOT be deprived the choice of qualified, medically-based trained CAAs. CAAs undergo rigorous and advanced graduate education in accredited master's degree programs ranging from 24 to 28 months, focusing on the Anesthesia Care Team approach to anesthesia practice. As a pre-requisite for admissions, applicants must hold a bachelor's degree, complete the same pre-medical course work that physicians complete, and score competitively in upper percentiles on the MCAT (Medical College Admission Test). CAAs are as safe and effective as nurse anesthetists and there is peer-reviewed, credible evidence to support this position. A 2018 study published in the peer-reviewed journal Anesthesiology confirmed the safety and efficacy of CAAs when it examined care between an anesthesiologist – nurse anesthetist team and an anesthesiologist – anesthesiologist assistant team. The results found "the specific composition of the anesthesia care team was not associated with any significant differences in mortality, length of stay, or inpatient spending." My anesthesiologist colleagues who work with both CAAs and nurse anesthetists can attest to the complete interchangeability of the two types of non-physician anesthesia providers. CAAs and nurse anesthetists have identical patient care responsibilities and technical capabilities – a view in harmony with their equivalent treatment under the Medicare Program. I want to thank you for your initial draft finding in favor of licensing CAAs in Washington State and strongly urge you to continue to support this position as you draft the final report, for the reasons highlighted above. Thank you for your consideration.

Sincerely,

Dr. Lennart Schenck MD

As an anesthesiologist and Washington State citizen, I am writing to thank you for your draft Report to the Legislature finding in favor of the proposal to license certified anesthesiologist assistants (CAAs) in our state and to urge you to continue this favorable support in your final report. Currently, anesthesiologists have only one option for a non-physician anesthesia provider – authorizing CAAs to practice here would expand that option to include an additional provider. Moreover, it would bring additional qualified mid-level providers to our state, and importantly, would provide our patients with access to the benefits CAAs already provide to nearly 20 other jurisdictions. CAAs are highly trained master's degree level non-physician anesthesia care providers. They work under the medical direction of anesthesiologists to implement anesthesia care plans. CAAs work exclusively within the Anesthesia Care Team environment as described by ASA. The Anesthesia Care Team consists of a supervising

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Dr. Glenn Powers

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Dr. Tony P. Tsai M.D., MBA

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Dr. Erik White M.D.

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Sincerely, Dr. Lauren R. Steffel

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Sincerely, Dr. John S. Whittington M.D.

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Sincerely, Dr. Thomas L. Rademacher D.O.

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Dr. MJ Dennison Romnek

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Sincerely,

Dr. CD Redger Jr

As an anesthesiologist and Washington State citizen, I am writing to thank you for your draft Report to the Legislature finding in favor of the proposal to license certified anesthesiologist assistants (CAAs) in our state and to urge you to continue this favorable support in your final report. Currently, anesthesiologists have only one option for a non-physician anesthesia provider – authorizing CAAs to practice here would expand that option to include an additional provider. Moreover, it would bring additional qualified mid-level providers to our state, and importantly, would provide our patients with access to the benefits CAAs already provide to nearly 20 other jurisdictions. CAAs are highly trained master's degree level non-physician anesthesia care providers. They work under the medical direction of anesthesiologists to implement anesthesia care plans. CAAs work exclusively within the Anesthesia Care Team environment as described by ASA. The Anesthesia Care Team consists of a supervising anesthesiologist and from 1 to 4 non-physician anesthesia providers (i.e., CAAs, nurse anesthetists, or anesthesiology physician residents/fellows). All CAAs possess a premedical undergraduate background and complete a comprehensive didactic and clinical program at the graduate school master's degree level. They are trained extensively in the delivery and maintenance of quality anesthesia care as well as advanced patient monitoring techniques. Hospitals and related institutions seeking to utilize the Anesthesia Care Team approach to patient care should be authorized to do so with any qualified anesthesia provider under physician-led care and NOT be deprived the choice of qualified, medically-based trained CAAs. CAAs undergo rigorous and advanced graduate education in accredited master's degree programs ranging from 24 to 28 months, focusing on the Anesthesia Care Team approach to anesthesia practice. As a pre-requisite for admissions, applicants must hold a bachelor's degree, complete the same pre-medical course work that physicians complete, and score competitively in upper percentiles on the MCAT (Medical College Admission Test). CAAs are as safe and effective as nurse anesthetists and there is peer-reviewed, credible evidence to support this position. A 2018 study published in the peer-reviewed journal Anesthesiology confirmed the safety and efficacy of CAAs when it examined care between an anesthesiologist – nurse anesthetist team and an anesthesiologist – anesthesiologist assistant team. The results found "the specific composition of the anesthesia care team was not associated with any significant differences in mortality, length of stay, or inpatient spending." My anesthesiologist colleagues who work with both CAAs and nurse anesthetists can attest to the complete interchangeability of the two types of non-physician anesthesia providers. CAAs and nurse anesthetists have identical patient care responsibilities and technical capabilities – a view in harmony with their equivalent treatment under the Medicare Program. I want to thank you for your initial draft finding in favor of licensing CAAs in Washington State and strongly urge you to continue to support this position as you draft the final report, for the reasons highlighted above. Thank you for your consideration.

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Dr. Benjamin H. Webster

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Dr. Brian P. McCoy M.D.

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Dr. Wendy Wang

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Dr. Airadion Omoruan

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Eric J. Shewmaker, MD

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Dr. Evan Thilo

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Dr. Scott B. Nelson

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Dr. AnGee Baldini

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Sincerely, Dr. Sundeep Malik M.D.

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Sincerely, Dr. Nicholas D Will

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Sincerely, Dr. Kurt L. Leinweber D.O.

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Sincerely, Dr. Wesley K. Greydanus M.D.

As an anesthesiologist and Washington State citizen, I am writing to thank you for your draft Report to the Legislature finding in favor of the proposal to license certified anesthesiologist assistants (CAAs) in our state and to urge you to continue this favorable support in your final report. Currently, anesthesiologists have only one option for a non-physician anesthesia provider – authorizing CAAs to practice here would expand that option to include an additional provider. Moreover, it would bring additional qualified mid-level providers to our state, and importantly, would provide our patients with access to the benefits CAAs already provide to nearly 20 other jurisdictions. CAAs are highly trained master's degree level non-physician anesthesia care providers. They work under the medical direction of anesthesiologists to implement anesthesia care plans. CAAs work exclusively within the Anesthesia Care Team environment as described by ASA. The Anesthesia Care Team consists of a supervising anesthesiologist and from 1 to 4 non-physician anesthesia providers (i.e., CAAs, nurse anesthetists, or anesthesiology physician residents/fellows). All CAAs possess a premedical undergraduate background and complete a comprehensive didactic and clinical program at the graduate school master's degree level. They are trained extensively in the delivery and maintenance of quality anesthesia care as well as advanced patient monitoring techniques. Hospitals and related institutions seeking to utilize the Anesthesia Care Team approach to patient care should be authorized to do so with any qualified anesthesia provider under physician-led care and NOT be deprived the choice of qualified, medically-based trained CAAs. CAAs undergo rigorous and advanced graduate education in accredited master's

degree programs ranging from 24 to 28 months, focusing on the Anesthesia Care Team approach to anesthesia practice. As a pre-requisite for admissions, applicants must hold a bachelor's degree, complete the same pre-medical course work that physicians complete, and score competitively in upper percentiles on the MCAT (Medical College Admission Test). CAAs are as safe and effective as nurse anesthetists and there is peer-reviewed, credible evidence to support this position. A 2018 study published in the peer-reviewed journal Anesthesiology confirmed the safety and efficacy of CAAs when it examined care between an anesthesiologist – nurse anesthetist team and an anesthesiologist – anesthesiologist assistant team. The results found "the specific composition of the anesthesia care team was not associated with any significant differences in mortality, length of stay, or inpatient spending." My anesthesiologist colleagues who work with both CAAs and nurse anesthetists can attest to the complete interchangeability of the two types of non-physician anesthesia providers. CAAs and nurse anesthetists have identical patient care responsibilities and technical capabilities – a view in harmony with their equivalent treatment under the Medicare Program. I want to thank you for your initial draft finding in favor of licensing CAAs in Washington State and strongly urge you to continue to support this position as you draft the final report, for the reasons highlighted above. Thank you for your consideration.

Sincerely, Dr. David Auyong M.D.

As an anesthesiologist and Washington State citizen, I am writing to thank you for your draft Report to the Legislature finding in favor of the proposal to license certified anesthesiologist assistants (CAAs) in our state and to urge you to continue this favorable support in your final report. Currently, anesthesiologists have only one option for a non-physician anesthesia provider – authorizing CAAs to practice here would expand that option to include an additional provider. Moreover, it would bring additional qualified mid-level providers to our state, and importantly, would provide our patients with access to the benefits CAAs already provide to nearly 20 other jurisdictions. CAAs are highly trained master's degree level non-physician anesthesia care providers. They work under the medical direction of anesthesiologists to implement anesthesia care plans. CAAs work exclusively within the Anesthesia Care Team environment as described by ASA. The Anesthesia Care Team consists of a supervising anesthesiologist and from 1 to 4 non-physician anesthesia providers (i.e., CAAs, nurse anesthetists, or anesthesiology physician residents/fellows). All CAAs possess a premedical undergraduate background and complete a comprehensive didactic and clinical program at the graduate school master's degree level. They are trained extensively in the delivery and maintenance of quality anesthesia care as well as advanced patient monitoring techniques. Hospitals and related institutions seeking to utilize the Anesthesia Care Team approach to patient care should be authorized to do so with any qualified anesthesia provider under physician-led care and NOT be deprived the choice of qualified, medically-based trained CAAs. CAAs undergo rigorous and advanced graduate education in accredited master's degree programs ranging from 24 to 28 months, focusing on the Anesthesia Care Team approach to anesthesia practice. As a pre-requisite for admissions, applicants must hold a bachelor's degree, complete the same pre-medical course work that physicians complete, and score competitively in upper percentiles on the MCAT (Medical College Admission Test). CAAs are as safe and effective as nurse anesthetists and there is peer-reviewed, credible evidence to support this position. A 2018 study published in the peer-reviewed journal Anesthesiology confirmed the safety and efficacy of CAAs when it examined care between an anesthesiologist – nurse anesthetist team and an anesthesiologist – anesthesiologist assistant team. The results found "the specific composition of the anesthesia care team was not associated with any significant differences in mortality, length of stay, or inpatient spending." My anesthesiologist colleagues who work with both CAAs and nurse anesthetists can attest to the complete interchangeability of the two types of non-physician anesthesia providers. CAAs and nurse anesthetists have identical patient care responsibilities and technical capabilities – a view in harmony

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Sincerely, Dr. Phillip M. Bouterse M.D.

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Sincerely, Dr. Margaret M. Sedensky

As an anesthesiologist and Washington State citizen, I am writing to thank you for your draft Report to the Legislature finding in favor of the proposal to license certified anesthesiologist assistants (CAAs) in our state and to urge you to continue this favorable support in your final report. Currently, anesthesiologists have only one option for a non-physician anesthesia provider – authorizing CAAs to practice here would expand that option to include an additional provider. Moreover, it would bring additional qualified mid-level providers to our state, and importantly, would provide our patients with access to the benefits CAAs already provide to nearly 20 other jurisdictions. CAAs are highly trained master's degree level non-physician anesthesia care providers. They work under the medical direction of anesthesiologists to implement anesthesia care plans. CAAs work exclusively within the Anesthesia Care Team environment as described by ASA. The Anesthesia Care Team consists of a supervising anesthesiologist and from 1 to 4 non-physician anesthesia providers (i.e., CAAs, nurse anesthetists, or anesthesiology physician residents/fellows). All CAAs possess a premedical undergraduate background and complete a comprehensive didactic and clinical program at the graduate school master's degree level. They are trained extensively in the delivery and maintenance of quality anesthesia care as well as advanced patient monitoring techniques. Hospitals and related institutions seeking to utilize the Anesthesia Care Team approach to patient care should be authorized to do so with any qualified anesthesia provider under physician-led care and NOT be deprived the choice of qualified, medically-based trained CAAs. CAAs undergo rigorous and advanced graduate education in accredited master's degree programs ranging from 24 to 28 months, focusing on the Anesthesia Care Team approach to anesthesia practice. As a pre-requisite for admissions, applicants must hold a bachelor's degree, complete the same pre-medical course work that physicians complete, and score competitively in upper percentiles on the MCAT (Medical College Admission Test). CAAs are as safe and effective as nurse anesthetists and there is peer-reviewed, credible evidence to support this position. A 2018 study published in the peer-reviewed journal Anesthesiology confirmed the safety and efficacy of CAAs when it examined care between an anesthesiologist – nurse anesthetist team and an anesthesiologist – anesthesiologist assistant team. The results found "the specific composition of the anesthesia care team was not associated with any significant differences in mortality, length of stay, or inpatient spending." My anesthesiologist colleagues who work with both CAAs and nurse anesthetists can attest to the complete interchangeability of the two types of non-physician anesthesia providers. CAAs and nurse anesthetists have identical patient care responsibilities and technical capabilities – a view in harmony with their equivalent treatment under the Medicare Program. I want to thank you for your initial draft finding in favor of licensing CAAs in Washington State and strongly urge you to continue to support this position as you draft the final report, for the reasons highlighted above. Thank you for your consideration.

Sincerely, Jeffrey McLaren

As an anesthesiologist and Washington State citizen, I am writing to thank you for your draft Report to the Legislature finding in favor of the proposal to license certified anesthesiologist assistants (CAAs) in our state and to urge you to continue this favorable support in your final report. Currently, anesthesiologists have only one option for a non-physician anesthesia provider – authorizing CAAs to practice here would expand that option to include an additional provider. Moreover, it would bring additional qualified mid-level providers to our state, and importantly, would provide our patients with access to the benefits CAAs already provide to nearly 20 other jurisdictions. CAAs are highly trained master's degree level non-physician anesthesia care providers. They work under the medical direction of anesthesiologists to implement anesthesia care plans. CAAs work exclusively within the Anesthesia Care Team environment as described by ASA. The Anesthesia Care Team consists of a supervising

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Sincerely, Kenneth C. Ruth Jr

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Sincerely, Hamza H. Rabi

As an anesthesiologist and Washington State resident, I am writing to thank you for your draft Report to the Legislature finding in favor of the proposal to license certified anesthesiologist assistants (CAAs) in our state and to urge you to continue this favorable support in your final report. Currently, anesthesiologists have only one option for a non-physician anesthesia provider – authorizing CAAs to practice here would expand that option to include an additional provider. Moreover, it would bring additional qualified mid-level providers to our state, and importantly, would provide our patients with access to the benefits CAAs already provide to nearly 20 other jurisdictions. CAAs are highly trained master’s degree level non-physician anesthesia care providers. They work under the medical direction of anesthesiologists to implement anesthesia care plans. CAAs work exclusively within the Anesthesia Care Team environment as described by ASA. The Anesthesia Care Team consists of a supervising anesthesiologist and from 1 to 4 non-physician anesthesia providers (i.e., CAAs, nurse anesthetists, or anesthesiology physician residents/fellows). All CAAs possess a premedical undergraduate background and complete a comprehensive didactic and clinical program at the graduate school master’s degree level. They are trained extensively in the delivery and maintenance of quality anesthesia care as well as advanced patient monitoring techniques. Hospitals and related institutions seeking to utilize the Anesthesia Care Team approach to patient care should be authorized to do so with any qualified anesthesia provider under physician-led care and NOT be deprived the choice of qualified, medically-based trained CAAs. CAAs undergo rigorous and advanced graduate education in accredited master’s degree programs ranging from 24 to 28 months, focusing on the Anesthesia Care Team approach to anesthesia practice. As a pre-requisite for admissions, applicants must hold a bachelor’s degree, complete the same pre-medical course work that physicians complete, and score competitively in upper percentiles on the MCAT (Medical College Admission Test). CAAs are as safe and effective as nurse anesthetists and there is peer-reviewed, credible evidence to support this position. A 2018 study published in the peer-reviewed journal Anesthesiology confirmed the safety and efficacy of CAAs when it examined care between an anesthesiologist – nurse anesthetist team and an anesthesiologist – anesthesiologist assistant team. The results found “the specific composition of the anesthesia care team was not associated with any significant differences in mortality, length of stay, or inpatient spending.” My anesthesiologist colleagues who work with both CAAs and nurse anesthetists can attest to the complete interchangeability of the two types of non-physician anesthesia providers. CAAs and nurse anesthetists have identical patient care responsibilities and technical capabilities – a view in harmony with their equivalent treatment under the Medicare Program. I want to thank you for your initial draft finding in favor of licensing CAAs in Washington State and strongly urge you to continue to support this position as you draft the final report, for the reasons highlighted above. Thank you for your consideration.

Sincerely, Dr. Walter S. Quiroga Robles MD

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Sincerely, Dr. Bradley P. Karr M.D.

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Sincerely, Dr. Patrick L. Sinopole M.D.

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Sincerely, Dr. Michael A. Melvin M.D.

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Sincerely, Dr. B Stephen Lee M.D.

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Sincerely, Dr. Veronica C. Swanson

As an anesthesiologist and Washington State citizen, I am writing to thank you for your draft Report to the Legislature finding in favor of the proposal to license certified anesthesiologist assistants (CAAs) in our state and to urge you to continue this favorable support in your final report. Currently, anesthesiologists have only one option for a non-physician anesthesia provider – authorizing CAAs to practice here would expand that option to include an additional provider. Moreover, it would bring additional qualified mid-level providers to our state, and importantly, would provide our patients with access to the benefits CAAs already provide to nearly 20 other jurisdictions. CAAs are highly trained master's degree level non-physician anesthesia care providers. They work under the medical direction of anesthesiologists to implement anesthesia care plans. CAAs work exclusively within the Anesthesia Care Team environment as described by ASA. The Anesthesia Care Team consists of a supervising anesthesiologist and from 1 to 4 non-physician anesthesia providers (i.e., CAAs, nurse anesthetists, or anesthesiology physician residents/fellows). All CAAs possess a premedical undergraduate background and complete a comprehensive didactic and clinical program at the graduate school master's degree level. They are trained extensively in the delivery and maintenance of quality anesthesia care as well as advanced patient monitoring techniques. Hospitals and related institutions seeking to utilize the Anesthesia Care Team approach to patient care should be authorized to do so with any qualified anesthesia provider under physician-led care and NOT be deprived the choice of qualified, medically-based trained CAAs. CAAs undergo rigorous and advanced graduate education in accredited master's degree programs ranging from 24 to 28 months, focusing on the Anesthesia Care Team approach to

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Sincerely, Dr. Dominik Steck

As an anesthesiologist and Washington State citizen, I am writing to thank you for your draft Report to the Legislature finding in favor of the proposal to license certified anesthesiologist assistants (CAAs) in our state and to urge you to continue this favorable support in your final report. Currently, anesthesiologists have only one option for a non-physician anesthesia provider – authorizing CAAs to practice here would expand that option to include an additional provider. Moreover, it would bring additional qualified mid-level providers to our state, and importantly, would provide our patients with access to the benefits CAAs already provide to nearly 20 other jurisdictions. CAAs are highly trained master's degree level non-physician anesthesia care providers. They work under the medical direction of anesthesiologists to implement anesthesia care plans. CAAs work exclusively within the Anesthesia Care Team environment as described by ASA. The Anesthesia Care Team consists of a supervising anesthesiologist and from 1 to 4 non-physician anesthesia providers (i.e., CAAs, nurse anesthetists, or anesthesiology physician residents/fellows). All CAAs possess a premedical undergraduate background and complete a comprehensive didactic and clinical program at the graduate school master's degree level. They are trained extensively in the delivery and maintenance of quality anesthesia care as well as advanced patient monitoring techniques. Hospitals and related institutions seeking to utilize the Anesthesia Care Team approach to patient care should be authorized to do so with any qualified anesthesia provider under physician-led care and NOT be deprived the choice of qualified, medically-based trained CAAs. CAAs undergo rigorous and advanced graduate education in accredited master's degree programs ranging from 24 to 28 months, focusing on the Anesthesia Care Team approach to anesthesia practice. As a pre-requisite for admissions, applicants must hold a bachelor's degree, complete the same pre-medical course work that physicians complete, and score competitively in upper percentiles on the MCAT (Medical College Admission Test). CAAs are as safe and effective as nurse anesthetists and there is peer-reviewed, credible evidence to support this position. A 2018 study published in the peer-reviewed journal Anesthesiology confirmed the safety and efficacy of CAAs when it examined care between an anesthesiologist – nurse anesthetist team and an anesthesiologist – anesthesiologist assistant team. The results found "the specific composition of the anesthesia care team was not associated with any significant differences in mortality, length of stay, or inpatient spending." My anesthesiologist colleagues who work with both CAAs and nurse anesthetists can attest to the complete interchangeability of the two types of non-physician anesthesia providers. CAAs and nurse anesthetists have identical patient care responsibilities and technical capabilities – a view in harmony with their equivalent treatment under the Medicare Program. I want to thank you for your initial draft finding in favor of licensing CAAs in Washington State and strongly urge you to continue to support this position as you draft the final report, for the reasons highlighted above. Thank you for your consideration.

Sincerely, Ms. Connie Chon

As an anesthesiologist and Washington State citizen, I am writing to thank you for your draft Report to the Legislature finding in favor of the proposal to license certified anesthesiologist assistants (CAAs) in our state and to urge you to continue this favorable support in your final report. Currently, anesthesiologists have only one option for a non-physician anesthesia provider – authorizing CAAs to practice here would expand that option to include an additional provider. Moreover, it would bring additional qualified mid-level providers to our state, and importantly, would provide our patients with access to the benefits CAAs already provide to nearly 20 other jurisdictions. CAAs are highly trained master's degree level non-physician anesthesia care providers. They work under the medical direction of anesthesiologists to implement anesthesia care plans. CAAs work exclusively within the Anesthesia Care Team environment as described by ASA. The Anesthesia Care Team consists of a supervising anesthesiologist and from 1 to 4 non-physician anesthesia providers (i.e., CAAs, nurse anesthetists, or anesthesiology physician residents/fellows). All CAAs possess a premedical undergraduate background and complete a comprehensive didactic and clinical program at the graduate school master's degree level. They are trained extensively in the delivery and maintenance of quality anesthesia care as well as advanced patient monitoring techniques. Hospitals and related institutions seeking to utilize the Anesthesia Care Team approach to patient care should be authorized to do so with any qualified anesthesia provider under physician-led care and NOT be deprived the choice of qualified, medically-based trained CAAs. CAAs undergo rigorous and advanced graduate education in accredited master's degree programs ranging from 24 to 28 months, focusing on the Anesthesia Care Team approach to anesthesia practice. As a pre-requisite for admissions, applicants must hold a bachelor's degree, complete the same pre-medical course work that physicians complete, and score competitively in upper percentiles on the MCAT (Medical College Admission Test). CAAs are as safe and effective as nurse anesthetists and there is peer-reviewed, credible evidence to support this position. A 2018 study published in the peer-reviewed journal Anesthesiology confirmed the safety and efficacy of CAAs when it examined care between an anesthesiologist – nurse anesthetist team and an anesthesiologist – anesthesiologist assistant team. The results found "the specific composition of the anesthesia care team was not associated with any significant differences in mortality, length of stay, or inpatient spending." My anesthesiologist colleagues who work with both CAAs and nurse anesthetists can attest to the complete interchangeability of the two types of non-physician anesthesia providers. CAAs and nurse anesthetists have identical patient care responsibilities and technical capabilities – a view in harmony with their equivalent treatment under the Medicare Program. I want to thank you for your initial draft finding in favor of licensing CAAs in Washington State and strongly urge you to continue to support this position as you draft the final report, for the reasons highlighted above. Thank you for your consideration.

Sincerely, Dr. Tor Haakon Sandven

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Sincerely, Justin A Terracciano

As an anesthesiologist and Washington State citizen, I am writing to thank you for your draft Report to the Legislature finding in favor of the proposal to license certified anesthesiologist assistants (CAAs) in our state and to urge you to continue this favorable support in your final report. Currently, anesthesiologists have only one option for a non-physician anesthesia provider – authorizing CAAs to practice here would expand that option to include an additional provider. Moreover, it would bring additional qualified mid-level providers to our state, and importantly, would provide our patients with access to the benefits CAAs already provide to nearly 20 other jurisdictions. CAAs are highly trained master's degree level non-physician anesthesia care providers. They work under the medical direction of anesthesiologists to implement anesthesia care plans. CAAs work exclusively within the Anesthesia Care Team environment as described by ASA. The Anesthesia Care Team consists of a supervising anesthesiologist and from 1 to 4 non-physician anesthesia providers (i.e., CAAs, nurse anesthetists, or anesthesiology physician residents/fellows). All CAAs possess a premedical undergraduate background and complete a comprehensive didactic and clinical program at the graduate school master's degree level. They are trained extensively in the delivery and maintenance of quality anesthesia care as well as advanced patient monitoring techniques. Hospitals and related institutions seeking to utilize the Anesthesia Care Team approach to patient care should be authorized to do so with any qualified anesthesia provider under physician-led care and NOT be deprived the choice of qualified, medically-based trained CAAs. CAAs undergo rigorous and advanced graduate education in accredited master's degree programs ranging from 24 to 28 months, focusing on the Anesthesia Care Team approach to anesthesia practice. As a pre-requisite for admissions, applicants must hold a bachelor's degree, complete the same pre-medical course work that physicians complete, and score competitively in upper percentiles on the MCAT (Medical College Admission Test). CAAs are as safe and effective as nurse anesthetists and there is peer-reviewed, credible evidence to support this position. A 2018 study published in the peer-reviewed journal Anesthesiology confirmed the safety and efficacy of CAAs when it examined care between an anesthesiologist – nurse anesthetist team and an anesthesiologist – anesthesiologist assistant team. The results found "the specific composition of the anesthesia care team

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Sincerely, Dr. Patrick T. Miller

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Sincerely, Brandon Keum Suhk So

As an anesthesiologist and Washington State citizen, I am writing to thank you for your draft Report to the Legislature finding in favor of the proposal to license certified anesthesiologist assistants (CAAs) in our state and to urge you to continue this favorable support in your final report. Currently,

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Sincerely, Dr. Jonathan V Dang

As an anesthesiology resident, a future anesthesiologist, and Washington State citizen, I am writing to thank you for your draft Report to the Legislature finding in favor of the proposal to license certified anesthesiologist assistants (CAAs) in our state and to urge you to continue this favorable support in your final report. Currently, anesthesiologists have only one option for a non-physician anesthesia provider – authorizing CAAs to practice here would expand that option to include an additional provider. Moreover, it would bring additional qualified mid-level providers to our state, and importantly, would provide our patients with access to the benefits CAAs already provide to nearly 20 other jurisdictions. CAAs are highly trained master's degree level non-physician anesthesia care providers. They work under the medical direction of anesthesiologists to implement anesthesia care plans. CAAs work exclusively within the Anesthesia Care Team environment as described by ASA. The Anesthesia Care Team consists of a supervising anesthesiologist and from 1 to 4 non-physician anesthesia providers (i.e., CAAs, nurse anesthetists, or anesthesiology physician residents/fellows). All CAAs possess a premedical undergraduate background and complete a comprehensive didactic and clinical program at the graduate school master's degree level. They are trained extensively in the delivery and maintenance of quality anesthesia care as well as advanced patient monitoring techniques. Hospitals and related institutions seeking to utilize the Anesthesia Care Team approach to patient care should be authorized to do so with any qualified anesthesia provider under physician-led care and NOT be deprived the choice of qualified, medically-based trained CAAs. CAAs undergo rigorous and advanced graduate education in accredited

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Sincerely, Maciej Czarnecki

As an anesthesiologist and Washington State citizen, I am writing to thank you for your draft Report to the Legislature finding in favor of the proposal to license certified anesthesiologist assistants (CAAs) in our state and to urge you to continue this favorable support in your final report. Currently, anesthesiologists have only one option for a non-physician anesthesia provider – authorizing CAAs to practice here would expand that option to include an additional provider. Moreover, it would bring additional qualified mid-level providers to our state, and importantly, would provide our patients with access to the benefits CAAs already provide to nearly 20 other jurisdictions. CAAs are highly trained master's degree level non-physician anesthesia care providers. They work under the medical direction of anesthesiologists to implement anesthesia care plans. CAAs work exclusively within the Anesthesia Care Team environment as described by ASA. The Anesthesia Care Team consists of a supervising anesthesiologist and from 1 to 4 non-physician anesthesia providers (i.e., CAAs, nurse anesthetists, or anesthesiology physician residents/fellows). All CAAs possess a premedical undergraduate background and complete a comprehensive didactic and clinical program at the graduate school master's degree level. They are trained extensively in the delivery and maintenance of quality anesthesia care as well as advanced patient monitoring techniques. Hospitals and related institutions seeking to utilize the Anesthesia Care Team approach to patient care should be authorized to do so with any qualified anesthesia provider under physician-led care and NOT be deprived the choice of qualified, medically-based trained CAAs. CAAs undergo rigorous and advanced graduate education in accredited master's degree programs ranging from 24 to 28 months, focusing on the Anesthesia Care Team approach to anesthesia practice. As a pre-requisite for admissions, applicants must hold a bachelor's degree, complete the same pre-medical course work that physicians complete, and score competitively in upper percentiles on the MCAT (Medical College Admission Test). CAAs are as safe and effective as nurse anesthetists and there is peer-reviewed, credible evidence to support this position. A 2018 study published in the peer-reviewed journal Anesthesiology confirmed the safety and efficacy of CAAs when it examined care between an anesthesiologist – nurse anesthetist team and an anesthesiologist – anesthesiologist assistant team. The results found "the specific composition of the anesthesia care team was not associated with any significant differences in mortality, length of stay, or inpatient spending." My anesthesiologist colleagues who work with both CAAs and nurse anesthetists can attest to the complete interchangeability of the two types of non-physician anesthesia providers. CAAs and nurse anesthetists have identical patient care responsibilities and technical capabilities – a view in harmony with their equivalent treatment under the Medicare Program. I want to thank you for your initial draft finding in favor of licensing CAAs in Washington State and strongly urge you to continue to support this

position as you draft the final report, for the reasons highlighted above. Thank you for your consideration.

Sincerely, Dr. Rachel Weiss Clement Physician Anesthesiologist

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As an anesthesiologist and Washington State citizen, I am writing to thank you for your draft Report to the Legislature finding in favor of the proposal to license certified anesthesiologist assistants (CAAs) in our state and to urge you to continue this favorable support in your final report. Currently, anesthesiologists have only one option for a non-physician anesthesia provider – authorizing CAAs to practice here would expand that option to include an additional provider. Moreover, it would bring additional qualified mid-level providers to our state, and importantly, would provide our patients with access to the benefits CAAs already provide to nearly 20 other jurisdictions. CAAs are highly trained master's degree level non-physician anesthesia care providers. They work under the medical direction of anesthesiologists to implement anesthesia care plans. CAAs work exclusively within the Anesthesia Care Team environment as described by ASA. The Anesthesia Care Team consists of a supervising anesthesiologist and from 1 to 4 non-physician anesthesia providers (i.e., CAAs, nurse anesthetists, or anesthesiology physician residents/fellows). All CAAs possess a premedical undergraduate background and complete a comprehensive didactic and clinical program at the graduate school master's degree level. They are trained extensively in the delivery and maintenance of quality anesthesia care as well as advanced patient monitoring techniques. Hospitals and related institutions seeking to utilize the Anesthesia Care Team approach to patient care should be authorized to do so with any qualified anesthesia provider under physician-led care and NOT be deprived the choice of qualified, medically-based trained CAAs. CAAs undergo rigorous and advanced graduate education in accredited master's degree programs ranging from 24 to 28 months, focusing on the Anesthesia Care Team approach to anesthesia practice. As a pre-requisite for admissions, applicants must hold a bachelor's degree, complete the same pre-medical course work that physicians complete, and score competitively in upper percentiles on the MCAT (Medical College Admission Test). CAAs are as safe and effective as nurse anesthetists and there is peer-reviewed, credible evidence to support this position. A 2018 study published in the peer-reviewed journal Anesthesiology confirmed the safety and efficacy of CAAs when it examined care between an anesthesiologist – nurse anesthetist team and an anesthesiologist – anesthesiologist assistant team. The results found "the specific composition of the anesthesia care team was not associated with any significant differences in mortality, length of stay, or inpatient spending." My anesthesiologist colleagues who work with both CAAs and nurse anesthetists can attest to the complete interchangeability of the two types of non-physician anesthesia providers. CAAs and nurse anesthetists have identical patient care responsibilities and technical capabilities – a view in harmony with their equivalent treatment under the Medicare Program. I want to thank you for your initial draft finding in favor of licensing CAAs in Washington State and strongly urge you to continue to support this position as you draft the final report, for the reasons highlighted above. Thank you for your consideration.

Sincerely, Sonya Mehta, MD

As an anesthesiologist and Washington State citizen, I am writing to thank you for your draft Report to the Legislature finding in favor of the proposal to license certified anesthesiologist assistants (CAAs) in our state and to urge you to continue this favorable support in your final report. Currently, anesthesiologists have only one option for a non-physician anesthesia provider – authorizing CAAs to practice here would expand that option to include an additional provider. Moreover, it would bring additional qualified mid-level providers to our state, and importantly, would provide our patients with access to the benefits CAAs already provide to nearly 20 other jurisdictions. CAAs are highly trained master's degree level non-physician anesthesia care providers. They work under the medical direction of anesthesiologists to implement anesthesia care plans. CAAs work exclusively within the Anesthesia Care

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Sincerely, Dr. David C. Reeder

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it examined care between an anesthesiologist – nurse anesthetist team and an anesthesiologist – anesthesiologist assistant team. The results found “the specific composition of the anesthesia care team was not associated with any significant differences in mortality, length of stay, or inpatient spending.” My anesthesiologist colleagues who work with both CAAs and nurse anesthetists can attest to the complete interchangeability of the two types of non-physician anesthesia providers. CAAs and nurse anesthetists have identical patient care responsibilities and technical capabilities – a view in harmony with their equivalent treatment under the Medicare Program. I want to thank you for your initial draft finding in favor of licensing CAAs in Washington State and strongly urge you to continue to support this position as you draft the final report, for the reasons highlighted above. Thank you for your consideration.

Sincerely, Dr. Deepak Sharma

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Sincerely, Dr. Mark R Youngberg

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Sincerely, Dr. Trent Garcia

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Sincerely, Dr. Paul T. Mathews M.D.

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Sincerely, Dr. Michael G Foulks

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Sincerely, Dr. Tiffany J Kim

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Sincerely, Dr. Thuydung T. Trinh

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Sincerely, Dr. Todd R. Looney M.D.

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Sincerely, Dr. Mike Melin

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Sincerely, Dr. Ryan Cole

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Sincerely, Dr. Sheryl Marks M.D.

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Sincerely, Dr. Steven D. Crooks

As an anesthesiologist and Washington State citizen, I am writing to thank you for your draft Report to the Legislature finding in favor of the proposal to license certified anesthesiologist assistants (CAAs) in our state and to urge you to continue this favorable support in your final report. Currently, anesthesiologists have only one option for a non-physician anesthesia provider – authorizing CAAs to practice here would expand that option to include an additional provider. Moreover, it would bring additional qualified mid-level providers to our state, and importantly, would provide our patients with access to the benefits CAAs already provide to nearly 20 other jurisdictions. CAAs are highly trained master's degree level non-physician anesthesia care providers. They work under the medical direction of anesthesiologists to implement anesthesia care plans. CAAs work exclusively within the Anesthesia Care Team environment as described by ASA. The Anesthesia Care Team consists of a supervising anesthesiologist and from 1 to 4 non-physician anesthesia providers (i.e., CAAs, nurse anesthetists, or anesthesiology physician residents/fellows). All CAAs possess a premedical undergraduate background and complete a comprehensive didactic and clinical program at the graduate school master's degree level. They are trained extensively in the delivery and maintenance of quality anesthesia care as well as advanced patient monitoring techniques. Hospitals and related institutions seeking to utilize the Anesthesia Care Team approach to patient care should be authorized to do so with any qualified anesthesia provider under physician-led care and NOT be deprived the choice of qualified, medically-based trained CAAs. CAAs undergo rigorous and advanced graduate education in accredited master's degree programs ranging from 24 to 28 months, focusing on the Anesthesia Care Team approach to anesthesia practice. As a pre-requisite for admissions, applicants must hold a bachelor's degree, complete the same pre-medical course work that physicians complete, and score competitively in upper percentiles on the MCAT (Medical College Admission Test). CAAs are as safe and effective as nurse anesthetists and there is peer-reviewed, credible evidence to support this position. A 2018 study published in the peer-reviewed journal Anesthesiology confirmed the safety and efficacy of CAAs when it examined care between an anesthesiologist – nurse anesthetist team and an anesthesiologist – anesthesiologist assistant team. The results found "the specific composition of the anesthesia care team was not associated with any significant differences in mortality, length of stay, or inpatient spending." My anesthesiologist colleagues who work with both CAAs and nurse anesthetists can attest to the complete interchangeability of the two types of non-physician anesthesia providers. CAAs and nurse anesthetists have identical patient care responsibilities and technical capabilities – a view in harmony with their equivalent treatment under the Medicare Program. I want to thank you for your initial draft finding in favor of licensing CAAs in Washington State and strongly urge you to continue to support this position as you draft the final report, for the reasons highlighted above. Thank you for your consideration.

Sincerely, Dr. Katherine A. Podorean

As an anesthesiologist and Washington State citizen, I am writing to thank you for your draft Report to the Legislature finding in favor of the proposal to license certified anesthesiologist assistants (CAAs) in our state and to urge you to continue this favorable support in your final report. Currently, anesthesiologists have only one option for a non-physician anesthesia provider – authorizing CAAs to practice here would expand that option to include an additional provider. Moreover, it would bring additional qualified mid-level providers to our state, and importantly, would provide our patients with

access to the benefits CAAs already provide to nearly 20 other jurisdictions. I have a long history of working with CAAs while in Ohio for over 20 years. I found them to be tremendously helpful in delivering safe, high-quality care to my patients. If I were a patient, I would welcome them caring for either myself or my family. CAAs are highly trained master's degree level non-physician anesthesia care providers. They work under the medical direction of anesthesiologists to implement anesthesia care plans. CAAs work exclusively within the Anesthesia Care Team environment as described by ASA. The Anesthesia Care Team consists of a supervising anesthesiologist and from 1 to 4 non-physician anesthesia providers (i.e., CAAs, nurse anesthetists, or anesthesiology physician residents/fellows). All CAAs possess a premedical undergraduate background and complete a comprehensive didactic and clinical program at the graduate school master's degree level. They are trained extensively in the delivery and maintenance of quality anesthesia care as well as advanced patient monitoring techniques. Hospitals and related institutions seeking to utilize the Anesthesia Care Team approach to patient care should be authorized to do so with any qualified anesthesia provider under physician-led care and NOT be deprived the choice of qualified, medically-based trained CAAs. CAAs undergo rigorous and advanced graduate education in accredited master's degree programs ranging from 24 to 28 months, focusing on the Anesthesia Care Team approach to anesthesia practice. As a pre-requisite for admissions, applicants must hold a bachelor's degree, complete the same pre-medical course work that physicians complete, and score competitively in upper percentiles on the MCAT (Medical College Admission Test). I want to thank you for your initial draft finding in favor of licensing CAAs in Washington State and strongly urge you to continue to support this position as you draft the final report, for the reasons highlighted above. Thank you for your consideration.

Sincerely, Dr. Philip G. Morgan M.D.

As an anesthesiologist and Washington State citizen, I am writing to thank you for your draft Report to the Legislature finding in favor of the proposal to license certified anesthesiologist assistants (CAAs) in our state and to urge you to continue this favorable support in your final report. Currently, anesthesiologists have only one option for a non-physician anesthesia provider – authorizing CAAs to practice here would expand that option to include an additional provider. Moreover, it would bring additional qualified mid-level providers to our state, and importantly, would provide our patients with access to the benefits CAAs already provide to nearly 20 other jurisdictions. CAAs are highly trained master's degree level non-physician anesthesia care providers. They work under the medical direction of anesthesiologists to implement anesthesia care plans. CAAs work exclusively within the Anesthesia Care Team environment as described by ASA. The Anesthesia Care Team consists of a supervising anesthesiologist and from 1 to 4 non-physician anesthesia providers (i.e., CAAs, nurse anesthetists, or anesthesiology physician residents/fellows). All CAAs possess a premedical undergraduate background and complete a comprehensive didactic and clinical program at the graduate school master's degree level. They are trained extensively in the delivery and maintenance of quality anesthesia care as well as advanced patient monitoring techniques. Hospitals and related institutions seeking to utilize the Anesthesia Care Team approach to patient care should be authorized to do so with any qualified anesthesia provider under physician-led care and NOT be deprived the choice of qualified, medically-based trained CAAs. CAAs undergo rigorous and advanced graduate education in accredited master's degree programs ranging from 24 to 28 months, focusing on the Anesthesia Care Team approach to anesthesia practice. As a pre-requisite for admissions, applicants must hold a bachelor's degree, complete the same pre-medical course work that physicians complete, and score competitively in upper percentiles on the MCAT (Medical College Admission Test). CAAs are as safe and effective as nurse anesthetists and there is peer-reviewed, credible evidence to support this position. A 2018 study published in the peer-reviewed journal Anesthesiology confirmed the safety and efficacy of CAAs when it examined care between an anesthesiologist – nurse anesthetist team and an anesthesiologist – anesthesiologist assistant team. The results found "the specific composition of the anesthesia care team was not associated with any significant differences in mortality, length of stay, or inpatient spending." My anesthesiologist colleagues who work with both CAAs and nurse anesthetists can attest to the

complete interchangeability of the two types of non-physician anesthesia providers. CAAs and nurse anesthetists have identical patient care responsibilities and technical capabilities – a view in harmony with their equivalent treatment under the Medicare Program. I want to thank you for your initial draft finding in favor of licensing CAAs in Washington State and strongly urge you to continue to support this position as you draft the final report, for the reasons highlighted above. Thank you for your consideration.

Sincerely, Dr. Jeffrey R. Robinson M.D.

As an anesthesiologist and Washington State citizen, I am writing to thank you for your draft Report to the Legislature finding in favor of the proposal to license certified anesthesiologist assistants (CAAs) in our state and to urge you to continue this favorable support in your final report. Currently, anesthesiologists have only one option for a non-physician anesthesia provider – authorizing CAAs to practice here would expand that option to include an additional provider. Moreover, it would bring additional qualified mid-level providers to our state, and importantly, would provide our patients with access to the benefits CAAs already provide to nearly 20 other jurisdictions. CAAs are highly trained master's degree level non-physician anesthesia care providers. They work under the medical direction of anesthesiologists to implement anesthesia care plans. CAAs work exclusively within the Anesthesia Care Team environment as described by ASA. The Anesthesia Care Team consists of a supervising anesthesiologist and from 1 to 4 non-physician anesthesia providers (i.e., CAAs, nurse anesthetists, or anesthesiology physician residents/fellows). All CAAs possess a premedical undergraduate background and complete a comprehensive didactic and clinical program at the graduate school master's degree level. They are trained extensively in the delivery and maintenance of quality anesthesia care as well as advanced patient monitoring techniques. Hospitals and related institutions seeking to utilize the Anesthesia Care Team approach to patient care should be authorized to do so with any qualified anesthesia provider under physician-led care and NOT be deprived the choice of qualified, medically-based trained CAAs. CAAs undergo rigorous and advanced graduate education in accredited master's degree programs ranging from 24 to 28 months, focusing on the Anesthesia Care Team approach to anesthesia practice. As a pre-requisite for admissions, applicants must hold a bachelor's degree, complete the same pre-medical course work that physicians complete, and score competitively in upper percentiles on the MCAT (Medical College Admission Test). CAAs are as safe and effective as nurse anesthetists and there is peer-reviewed, credible evidence to support this position. A 2018 study published in the peer-reviewed journal Anesthesiology confirmed the safety and efficacy of CAAs when it examined care between an anesthesiologist – nurse anesthetist team and an anesthesiologist – anesthesiologist assistant team. The results found "the specific composition of the anesthesia care team was not associated with any significant differences in mortality, length of stay, or inpatient spending." My anesthesiologist colleagues who work with both CAAs and nurse anesthetists can attest to the complete interchangeability of the two types of non-physician anesthesia providers. CAAs and nurse anesthetists have identical patient care responsibilities and technical capabilities – a view in harmony with their equivalent treatment under the Medicare Program. I want to thank you for your initial draft finding in favor of licensing CAAs in Washington State and strongly urge you to continue to support this position as you draft the final report, for the reasons highlighted above. Thank you for your consideration.

Sincerely, Dr. Vikas N. O'Reilly-Shah M.D.

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I urge you to reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs). AAs do not improve access to care in Washington; in fact, there is reason to believe they will result in restricting access and driving up costs. AAs are narrowly trained and cannot practice without a licensed anesthesiologist. Finally, AAs are an unproven provider with no peer-reviewed studies that prove the safety of AAs.

Certified Registered Nurse Anesthetists (CRNAs) are certified anesthesia experts independently licensed to practice in all 50 states and the District of Columbia. Because of their extensive education and training, CRNAs are permitted by federal and state laws and regulations to provide every type of anesthesia service to patients without the involvement or presence of a physician anesthesiologist. All research studies on anesthesia safety and cost-effectiveness conducted in the last 20 years confirm that CRNAs provide the safest, most cost-effective anesthesia care to patients.

In contrast, AAs can only practice in 15 states plus the District of Columbia. They are limited by their training and licensure to providing clinical support to anesthesiologists and may not practice "apart from the supervision of an anesthesiologist," according to the American Academy of Anesthesiologist Assistants (AAAA). Because AAs are required to be directly supervised by an anesthesiologist, the AA/anesthesiologist team is one of the costliest anesthesia delivery models with no scientific evidence of increased patient safety.

Because AAs cannot practice without anesthesiologist supervision, AAs do not practice in rural areas where CRNAs working without anesthesiologist involvement are the primary providers of anesthesia care. In fact, CRNAs are the only anesthesia provider in 72% of Washington's rural hospitals. AAs, in contrast, can only practice where anesthesiologists practice, which greatly limits their utilization. AAs, therefore, can't help solve problems of inadequate access to anesthesia care in rural and underserved communities.

If for any reason an AA's supervising anesthesiologist is not available, off-site, on vacation, or simply home for the day, the AA may not provide anesthesia care. The AA anesthesiologist- driven mode of practice, therefore, is inflexible and fails to adequately meet the needs of patients, hospitals, ambulatory surgical centers, or other healthcare settings.

While nurse anesthesia educational programs graduate nurse anesthetists prepared for autonomous practice, the AA program curriculum is characterized by training that only allows them to assist anesthesiologists in technical functions.

Because CRNAs do not need to practice with an anesthesiologist, they are much more cost effective than AAs. With an AA, the need exists to educate and use two providers – the

supervising anesthesiologist and the AA – to provide anesthesia care to one patient. With a CRNA, only that individual is needed to provide total anesthesia care to the patient. Essentially, compared with the anesthesiologist-AA staffing arrangement, one CRNA can provide the care of two providers.

AAs are an unproven provider. No peer-reviewed studies in scientific journals have been published regarding the quality of care of AA practice or AA anesthesia outcomes. The quality of care that AAs provide is unproven, as there is no meaningful research data concerning AA anesthesia safety. In contrast, the excellent, safe anesthesia care that CRNAs provide and associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.

It makes no sense to authorize AAs, a less qualified anesthesia provider that can only work with anesthesiologists and can't be used in any area where anesthesiologists don't practice, such as many rural locations. Please reject the application for licensure of anesthesiologist assistants.

Sincerely, Leviticus J. Crowder, CRNA

American Society of Anesthesiologists™

1061 American Lane | Schaumburg, IL 60173-4973 | (847) 825-5586
905 16th Street N.W. | Washington, D.C. 20006 | (202) 289-2222

September 23, 2021

Sherry Thomas
Anesthesiologist Assistant Sunrise Review Lead
Health Systems Quality Assurance
Washington State Department of Health

Re: Support of Draft Report to the Legislature in Favor of Certified Anesthesiologist Assistant Licensure

Dear Ms. Thomas,

On behalf of the more than 54,000 members of the American Society of Anesthesiologists (ASA), **I am writing in strong support of the Washington State Department of Health's (Department) recommendation in favor of Certified Anesthesiologist Assistant (CAA) licensure in Washington State,** found in the Department's recent draft Report to the Legislature.[1] Licensure of these non-physician anesthetists would allow CAAs to utilize their unique team-based skills and practice in Washington State, as well as provide your residents access to the benefits CAAs provide — benefits that patients in nearly 20 jurisdictions[2] already receive from CAAs.

ASA appreciates the opportunity to comment on the Department's draft Report to the Legislature. Our comments will address the draft's language concerning supervision and scope of practice. Our comments also review ASA policy, Anesthesia Care Team background, CAA education and training, and the identical responsibilities and capabilities of CAAs and nurse anesthetists.

Within the Detailed Recommendations section of the draft language beginning at page 18, ASA supports clarifying the definition of supervision. Specifically, we recommend amending the language to align with the language found in the Medicare Conditions of Participation for anesthesia services[3] by referencing "immediately available" to help clarify the definition of supervision. ASA's definition of "immediately available" means "a medically directing anesthesiologist…is in physical proximity that allows the anesthesiologist to re-establish direct contact with the patient to meet medical needs

[1] See Report to the Legislature, Sunrise Review, Anesthesiologist Assistant available at https://www.doh.wa.gov/Portals/1/Documents/2000/2021/2021DraftAnesthesAsstSunrise.pdf
[2] Alabama, Colorado, District of Columbia, Florida, Georgia, Guam, Kansas, Kentucky, Indiana, Michigan, Missouri, New Mexico, North Carolina, Ohio, Oklahoma, South Carolina, Texas, Vermont, Wisconsin
[3] 42 CFR § 482.52

and any urgent or emergency clinical problems."[4] This definition maintains the highest level of patient safety standards while taking into account the differences in design and size of various facilities that make it impossible to define a universally applicable specific time or distance for physical proximity.

Also, within the Detailed Recommendations section of the draft language beginning at page 18, we recommend maintaining the proposed scope of practice. This language is consistent with ASA's view that CAAs and nurse anesthetists share identical patient care responsibilities, a comparable knowledge base, and comparable technical skills.[5] As such, ASA recommends parity between anesthesiologist assistant and nurse anesthetist scope of practice. The primary difference between the two professions being that CAAs work under the medical direction of physician anesthesiologists to implement anesthesia care plans. This model, described in detail below, is known as the Anesthesia Care Team (ACT) and is one of the safest methods to administer anesthesia care to patients.

ASA Policy

ASA strongly believes in the ACT and supports CAA practice authorization in all states.[6] We actively encourage our members to promote enabling legislation that would authorize licensing of CAAs.

CAAs are Key Members of the Anesthesia Care Team

CAAs are highly trained master's degree level non-physician anesthesia care providers. They work under the medical direction of physician anesthesiologists, exclusively within the ACT environment as described by ASA. ACTs consist of a supervising anesthesiologist and from 1 to 4 non-physician anesthesia providers (i.e., CAAs, nurse anesthetists, or anesthesiology physician residents/fellows). All CAAs possess a premedical undergraduate background and complete a comprehensive didactic and clinical program at the graduate school master's degree level. They are trained extensively in the delivery and maintenance of quality anesthesia care as well as advanced patient monitoring techniques.

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[4] See ASA's Definition of "Immediately Available" when Medically Directing available at https://www.asahq.org/standards-and-guidelines/definition-of-immediately-available-when-medically-directing

[5] See Statement Comparing Anesthesiologist Assistant and Nurse Anesthetist Education and Practice available at https://www.asahq.org/standards-and-guidelines/statement-comparing-anesthesiologist-assistant-and-nurse-anesthetist-education-and-practice

[6] See ASA Standards, Guidelines and Statements: Statement on the Anesthesia Care Team available at http://www.asahq.org/~/media/Sites/ASAHQ/Files/Public/Resources/standards-guidelines/statement-on-the-anesthesia-care-team.pdf

When hospitals, surgery centers, and related institutions choose to utilize the physician-led ACT approach to patient care, those facilities should be authorized to do so with any qualified anesthesia provider and NOT be deprived the choice of qualified, medically-based trained CAAs.

Education & Training

CAAs undergo rigorous and advanced graduate education focusing on the ACT approach to anesthesia practice. The typical AA master's program is 24 to 28 months. As a pre-requisite for admissions, applicants must hold a bachelor's degree, complete the same pre-medical course work that physicians complete, and score competitively in upper percentiles on the MCAT (Medical College Admission Test). AA master's degree programs are accredited by the Commission for the Accreditation of Allied Health Educational Programs (CAAHEP), a national accrediting body certifying 2000 educational programs in 23 different allied health professions. AAs must pass a certification examination administered by the NCCAA (National Commission for Certification of Anesthesiologist Assistants) in collaboration with the National Board of Medical Examiners. Finally, they must complete 40 hours of continuing medical education every two years and complete a recertification exam every six years.

CAAs and Nurse Anesthetists Are Clinically Interchangeable

CAAs are as safe and effective as nurse anesthetists. There is no peer-reviewed or other credible evidence of any sort that the care provided by a CAA is less safe than that of a nurse anesthetist. Authorizing CAAs to practice would allow physician anesthesiologists in your state to work with either or both non-physician anesthetists, similar to physicians in other medical specialties interchanging nurse practitioners with physician assistants. My physician anesthesiologist colleagues who work with both CAAs and nurse anesthetists can attest to the complete interchangeability of the two types of non-physician anesthesia providers.

Throughout more than four decades where physician anesthesiologists and CAAs have worked together, patients have enjoyed increased access to care with a demonstrated and impeccable safety record. More than 80 percent of all anesthetics throughout the United States are delivered in the ACT model of care. The supervising physician anesthesiologist does not perform their own cases while supervising ACT members and must be immediately available at all times. ACTs operate in every state in the country and this type of practice is a long established and safe model for providing anesthesia care.

It is the position of ASA that both CAAs and nurse anesthetists have identical patient care responsibilities and technical capabilities – a view in harmony with their equivalent treatment under the Medicare Program. The proven safety of the ACT approach to

anesthesia with either CAAs or nurse anesthetists serving as the non-physician anesthetists confirms the wisdom of this view. Moreover, a 2018 study published in the peer-reviewed journal *Anesthesiology* further confirmed this fact when it examined care between a physician anesthesiologist – nurse anesthetist team and a physician anesthesiologist – anesthesiologist assistant team. The results found "the specific composition of the anesthesia care team was not associated with any significant differences in mortality, length of stay, or inpatient spending."[7]

Conclusion

Thank you for the opportunity to provide input on the Department's recommendations and for your consideration of this important effort. On behalf of ASA, I strongly support the Department's recommendation in favor of CAA licensure in Washington State and urge you to continue showing this support in your final Report to the Legislature. Authorizing CAAs to practice will allow your citizens to benefit from the highly trained care CAAs currently provide in nearly 20 jurisdictions. Should you have any questions, please feel free to contact Jason Hansen, MS, JD, Director of State Affairs, at j.hansen@asahq.org.

Sincerely,

Beverly K Philip MD

Beverly K. Philip, MD, FACA, FASA
President

[7] Sun EC, Miller TR, Moshfegh J, Baker LC. Anesthesia care team composition and surgical outcomes. *Anesthesiology* 2018; 129:700-09

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
Nursing Care Quality Assurance Commission
P.O. Box 47864
Olympia, WA 98504-7864

Sunrise Reviews in Progress
Nursing Care Quality Assurance Commission (NCQAC) Comments
Approved September 9, 2021

Anesthesiologist Assistant Scope of Practice

We are providing the following Nursing Commission comments on whether the proposal meets the criteria in chapter 18.120 RCW.

Does not meet criteria RCW 18.120.010.2 (b) and (c):

Currently there are two professions providing safe effective anesthesia services in Washington State. Certified Registered Nurse Anesthetists (CRNAs) and anesthesiologists are both licensed independent practitioners. There is a century of evidence that supports the safe autonomous practice of CRNAs, the same is not true for anesthesiologist assistants. CRNAs and anesthesiologists practicing autonomously is the most cost effective, safe and flexible care delivery model.

Paula R. Meyer MSN, RN, FRE
Paula R. Meyer MSN, RN, FRE
Executive Director
NCQAC

Laurie Soine ARNP, PhD
Laurie Soine PhD, ARNP
Chair
NCQAC

Washington State Society of Anesthesiologists

September 24, 2021

Sherry Thomas
Anesthesiologist Assistant Sunrise Review Lead
Health Systems Quality Assurance
Washington State Department of Health

Re: Support of Draft Report to the Legislature in Favor of Certified Anesthesiologist Assistant Licensure

Dear Ms. Thomas,

The Washington State Society of Anesthesiologists (WSSA) is pleased to support the draft report from the Department of Health recommending licensure for Certified Anesthesiologist Assistants (CAAs) in Washington. The WSSA was founded in 1948. It was formed to advance the science and art of anesthesiology, and to stimulate interest and promote progress in that specialty. It is a Washington State non-profit corporation and is a component society of the American Society of Anesthesiologists (ASA).

The WSSA appreciates the opportunity to comment on the draft report and respond to the Department's recommendations.

The Department of Health's first detailed recommendation was to clarify the definition of "supervision" to require the supervising anesthesiologist to be present in the operating suite, office, obstetrical unit, or other setting; and present in the operating room during induction of general or regional anesthesia or emergence from general anesthesia.

The WSSA agrees with the recommendation to clarify the definition of supervision and recommends referencing "immediately available" in the statute. **The ASA guidelines state *"A medically directing anesthesiologist is immediately available if s/he is in physical proximity that allows the anesthesiologist to re-establish direct contact with the patient to meet medical needs and any urgent or emergency clinical problems."***.[1] In addition to aligning with national guidelines, adding this clarification to the proposed legislation is consistent with the Medicare Conditions of Participation for anesthesia services (42 CFR § 482.52).

The Department's next recommendation was to narrow the scope of practice for CAAs and make the following key changes: authorize "assisting the supervising anesthesiologist" with the performance of general anesthesia and epidural, spinal, and intravenous regional anesthesia, rather than performing it;

[1] See ASA's Definition of "Immediately Available" when Medically Directing available at https://www.asahq.org/standards-and-guidelines/definition-of-immediately-available-when-medically-directing

2150 N. 107th Suite 205, Seattle, WA 98133 206-209-5266
office@wa-anesthesiology.org www.wa-anesthesiology.org

authorize "administering," rather than "ordering," medications; and remove the authority to order postoperative sedation or analgesia, oxygen or respiratory therapy, or medicine.

The WSSA agrees that some additional clarification regarding the scope of practice defined in the legislation could be beneficial, and we recommend the following:

Authorizing "assisting" rather than "performing," and adding a definition for "assists."

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

Clarifying that CAAs do not have prescriptive authority by authorizing "administering" rather than "ordering" medications, and revising the sections on postoperative care. As such, we recommend striking Section 5 (c) (f) (w) (x) (y) and instead, inserting the following language:

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

Finally, the Department recommends eliminating the advisory committee recommended in Section 3 of the proposed legislation because it is redundant. The WSSA agrees.

Authorizing CAAs to practice will allow anesthesiologists in our state to work with both nurse anesthetists and CAAs, similar to physicians in other medical specialties interchanging nurse practitioners with physician assistants. It will expand access to care in a safe and cost-effective manner. CAAs are highly trained graduate level non-physician anesthesia care providers, and they are as safe and effective as nurse anesthetists. There is no credible evidence to the contrary.

Thank you for the opportunity to provide feedback and clarity regarding the Department's recommendations. The WSSA supports the draft report and its preliminary conclusion that the state should adopt licensure for CAAs.

If you have any questions, please don't hesitate to contact WSSA at office@wa-anesthesiology.org.

Sincerely,

S. [illegible], M.D.

Stephanie Yang, MD, FASA
WSSA President

2150 N. 107th Suite 205, Seattle, WA 98133 206-209-5266
office@wa-anesthesiology.org www.wa-anesthesiology.org

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Washington Office
20 F Street, NW Suite 1000
Washington, DC 20001
Voice: 202-337-2701
Fax: 202-337-4271
E-mail: djohnson@facs.org

facs.org

September 23, 2021

Sherry Thomas
Anesthesiologist Assistant Sunrise Review Lead
Health Systems Quality Assurance
Washington State Department of Health

Dear Ms. Thomas:

The American College of Surgeons (ACS) is the largest surgical organization with over 80,000 members worldwide. The ACS supports the Washington State Department of Health's draft report to recommend licensure of Certified Anesthesiologist Assistants (CAAs).

Licensure of CAAs will help ensure surgical patients in Washington State receive high quality anesthesia care from those who are well-educated and trained to provide this care. CAAs are highly skilled health professionals who work under the direction of licensed physician anesthesiologists to implement anesthesia care plans.

Certified Anesthesiologist Assistants have successfully practiced for many years in 17 jurisdictions under the supervision of physician anesthesiologists within the confines of the surgical/anesthesia team, providing high quality anesthesia services with good surgical patient outcomes. Upon completion of their education which includes a minimum of 2,000 clinical hours of training, they receive a Master's degree. Additionally, they receive certification after successful completion of the certifying exam administered by the National Commission for Certification of Anesthesiologist Assistants.

Physician anesthesiologists and surgeons have worked well with CAAs for many years; permitting licensure of this qualified health care provider would be beneficial to Washington State's citizens.

Sincerely,

David B. Hoyt

David B. Hoyt, MD, FACS
Executive Director

Jennifer A. Larson, CRNA, DNAP
6832 South Blackwing Court
Spokane, WA 99224
(509) 850-7921
jenlarsoncrna@gmail.com

September 29, 2021

Washington Department of Heath
Sunrise Review Panel Members
P.O. Box 47879
Olympia, WA 98504

Dear Sunrise Review Panel Member:

As a Certified Registered Nurse Anesthetist (CRNA), a member of the Washington Association of Nurse Anesthetists (WANA), and a member of the American Association of Nurse Anesthetists (AANA), I ask you to deny the sunrise review application regarding the introduction of licensure for Anesthesiologist Assistants (AAs) in Washington State. Currently in Washington State anesthesia care is delivered effectively, and without shortage, by Anesthesiologists and CRNAs; there is no shortage in access to anesthesia services in this state and therefor no need to introduce AAs. In fact, the introduction of AAs would not improve access to care and would effectively drive-up costs of anesthesia services since AAs cannot practice independently without a licensed anesthesiologist. The quality of anesthesia care should be highly questioned when associated with AAs due to their unproven track record in other states, inferior educational standards, and no peer-reviewed studies to prove their safety and cost effectiveness.

Currently in Washington all anesthesia care is delivered either by a Medical Doctor in the specialty of Anesthesia - an Anesthesiologist (MDA), or by a Master's or Doctorate prepared Advanced Practice Nurse in the specialty of Anesthesia – a CRNA. Both MDAs and CRNAs are licensed to provide a full scope of anesthesia services independently in this state, without the supervision of each other. The safety and cost effectiveness of anesthesia services provided by MDAs and CRNAs independently is well documented and has proven itself over the course of time. There is not believed to be a shortage in anesthesia services in Washington state, especially in the rural areas due to the ability of CRNAs to provide independent full scope anesthesia care.

AAs would not increase access to anesthesia services in Washington because they cannot provide a full scope of anesthesia and must be closely supervised by an onsite anesthesiologist. In effect, by utilizing an AA, you would be replacing a single independent provider (CRNA or MDA) with the need for two providers, an AA and supervising anesthesiologist. The work of one would now become the work of two, increasing cost to the hospitals, clinics, Medicare, Medicaid, and ultimately patients.

The educational standards for AAs should be highly scrutinized. Most AA programs do not require any patient care experience or an undergraduate degree in healthcare prior to admittance into the program. Because AAs are not fully trained as physician assistants (PAs), American Academy of physician Assistants (AAPA) opposes states to characterize AA as PAs. PAs are intensely trained in generalized medical education and can often transition easily among specialties; whereas AAs are not trained generally in medicine and are only trained to deliver anesthesia care as part of a care team under anesthesiologist direction. AAs and PAs sit for different national certification examinations and therefor hold unequal certifications. In contrast the training of MDAs and CRNAs is time proven, well rounded, and comprehensive. Prior to admission to CRNA school, the applicant must have a bachelor's degree in nursing and have at a minimum of 2 years of critical care nursing experience in intensive care units. The anesthesia education for CRNAs extends 2.5 – 4 years beyond the undergraduate nursing degree and includes more than 2,000 hours of clinical anesthesia experience beyond didactic education. Most CRNA education programs produce doctoral degrees as most master's programs are transitioning to doctorate level programs.

The safety of AAs is unproven. There are no peer-reviewed studies that have been published regarding the safety and quality of anesthesia care when provided by an AA in a care team model. AAs limited generalized medical training and limited prior patient care or experience in healthcare justify the questioning of safety in AA practice. In contrast, the excellence in providing safe and cost-effective anesthesia care, and expanding access to full scope of anesthesia services has been repeatedly documented in peer-reviewed studies and published in prominent scientific and healthcare journals.

When considering the sunrise review for the introduction of AAs in Washington state I urge you to think about who you would want to provide anesthesia care for yourself, your child, your parent, or your other loved ones. Do you want an under-educated AA who cannot provide the full scope of anesthesia services without close supervision of an Anesthesiologist? Or do you want a time proven provider with a vast experience in providing critical patient care with a high-quality anesthesia specialized education? Please protect the patients in Washington state from the unsafe, unnecessary introduction of AAs in Washington. As a citizen of, and a CRNA in Washington state, I ask you to reject the application for licensure of anesthesiologist assistants.

Sincerely,

Dr. Jennifer A. Larson

Enclosures: crna-aa-side-by-side-comparison.pdf
crna-vs-aa-infographic.pdf
aa-reduced-revenue-infograghic.pdf

CRNA VS. AA

Certified Registered Nurse Anesthetists

AUTONOMOUS, safe, cost-effective—ensure access to care

CRNAs are educated to be an **AUTONOMOUS** anesthesia provider and are qualified to make **INDEPENDENT** judgements regarding all aspects of anesthesia care. CRNAs and anesthesiologists can work **INDEPENDENT** of one another or together.

The most cost-effective anesthesia delivery model is a CRNA working **AUTONOMOUSLY**. A CRNA working **AUTONOMOUSLY** can provide the care that requires two providers when the anesthesiologist-AA model is used.

CRNAs work in urban and rural areas, and across all types of practice settings. CRNAs working without anesthesiologist involvement are the primary providers of anesthesia care in rural areas.

CRNAs are **AUTONOMOUS** within a patient care team regardless of the composition of that team. CRNAs provide high quality anesthesia care with or without physician oversight.

CRNAs provide quality care with or without physician oversight. When working in the anesthesia care team, if there is no supervision, the facility simply bills exclusive of the anesthesiologist for the procedure (QZ vs. medical direction).

CRNAs are educated and trained to work with or without physician involvement and are capable of high-level **AUTONOMOUS** function and judgement.

Applicants for nurse anesthesia programs have acquired extensive clinical experience in a variety of areas such as coronary, respiratory, postanesthesia, and surgical intensive care units before they begin their nurse anesthesia programs.

CRNAs receive 7-8 ½ years of formal education and preparation, from commencement of the professional education in nursing to graduation from nurse anesthesia school. During the course of their education, CRNAs will typically have acquired, on average, 8,636 hours of clinical patient care experience.

Anesthesiologist **ASSISTANTS**

DEPENDENT, costly—do not improve access to care

AAs are trained to be an **ASSISTANT, DEPENDENT** practitioner and cannot work autonomously; they can only work under the direct supervision of an anesthesiologist[1].

AAs are **DEPENDENT** practitioners that must work with a supervising anesthesiologist; therefore, it takes two providers to provide anesthesia care to one patient, which is not a cost-effective model of care.

AAs are **DEPENDENT** practitioners who cannot expand access to care. AAs cannot help solve problems of inadequate access to anesthesia care in rural and underserved communities.

AAs are **DEPENDENT** practitioners who are not trained to make autonomous decisions when there are lapses in supervision[2].

AAs are **DEPENDENT** practitioners that create an environment for Medicare fraud. AAs cannot provide care without direct supervision, leading to possible unauthorized independent practice.

AAs are **DEPENDENT** providers who can only take delegated orders from an anesthesiologist.

AA programs do not require any nursing, medical, anesthesia or healthcare education, experience, licensure, or certification for admission into an AA program.

Clinical hours for AA programs include experiences such as learning to do physicals, taking patient histories, training and certification processes for life support training, and other learning experiences that a licensed professional RN has already mastered prior to nurse anesthesia program entry. During their AA program, AAs students average 2,600 hours of clinical anesthesia education.

1 As used in this document, "supervision" also refers to "medical direction" under TEFRA (Tax Equity and Fiscal Responsibility Act of 1982).

2 "Lapse in supervision" is the inability of a supervising anesthesiologist in an anesthesia care team to be physically present at "bedside" during required (most important) aspects of a case as specified under TEFRA.

AANA

AANA.com

WHAT (STATE) LAWMAKERS NEED TO KNOW ABOUT

CRNAs vs. AAs

There is no shortage of Certified Registered Nurse Anesthetists (CRNAs) or physician anesthesiologists to provide safe, high-quality anesthesia care to patients in (State). Currently, anesthesiologist assistants (AAs) are not a recognized healthcare provider in (State) for ***many reasons***.

CRNAs Independent, safe, cost-effective—ensure access to care	AAs Dependent, costly—do not improve access to care
CRNAs...and anesthesiologists ***can work independent of one another OR together*** by law to ensure patients access to surgical, obstetrical, emergency and pain management services in rural and urban locations across the state.	**AAs...*cannot work independently;*** they can ***only work under the direct supervision[1] of an anesthesiologist,*** dramatically limiting ***where*** and ***when*** they can provide patient care.
CRNAs...are educated and trained to ***work independently*** (without an anesthesiologist).	**AAs...**are educated and trained to ***assist*** anesthesiologists.
CRNAs...*may* work in an anesthesia care team (with an anesthesiologist), but ***are not required*** to do so.	**AAs...*must*** work in an anesthesia care team with an anesthesiologist.
CRNAs...working in a care team will ***continue to provide patient care*** if there is a ***lapse in supervision.***[2]	**AAs...*legally cannot provide patient care*** if there is a ***lapse in supervision.***
CRNAs...provide high quality care regardless of whether anesthesiologist supervision requirements are met.[1] In such cases, the facility simply bills ***exclusive of the anesthesiologist*** for the procedure (***QZ vs. medical direction***).	**AAs...*cannot provide care without direct supervision***, leading to possible ***case delays*** or even ***unauthorized independent practice, regulatory violations, and accreditation jeopardy for facilities***.

Other CRNA Advantages

Since 2000, multiple research studies confirm that CRNAs are ***safe, high-quality*** anesthesia providers—***as safe as physician anesthesiologists.***

The ***most cost-effective anesthesia delivery model*** is a CRNA working independently; the most expensive is one anesthesiologist supervising another provider.

CRNAs: Ensuring patients access to safe, cost-effective anesthesia care

1 As used in this document, "supervision" also refers to "medical direction" under TEFRA (Tax Equity and Fiscal Responsibility Act of 1982).

2 "Lapse in supervision" is the inability of a supervising anesthesiologist in an anesthesia care team to be physically present at "bedside" during required (most important) aspects of a case as specified under TEFRA.

Logo Here

(State) Association of Nurse Anesthetists

STATEwebsite.org

AAs Anesthesiologist ASSISTANTS

INFLEXIBLE STAFFING STRUCTURE POTENTIAL REDUCED REVENUE

AAs are **only** able to provide anesthesia care **under the direct supervision** of a physician anesthesiologist.

Physician anesthesiologists can only bill for AAs when medical direction criteria are met.

AAs CANNOT work Autonomously

AAs CANNOT Collaborate with Surgeons or Proceduralists

Medical Direction (QK) TEFRA[1] Compliance Capability

(2:1 Ratio)

AA + ANES[2]

12 + 6

Staffing Cost[3]

4.52M

Failed Medical Direction (QK) defer to Supervision (AD) Billing

(3:1 Ratio)

AA + ANES[2]

12 + 4

Staffing Cost[3]

3.68M

Significant Risk For Medicare Fraud

Reduced Revenue

- **AAs must work** in an Anesthesia Care Team Model generally billed under Medical Direction billing model with no more than a 4:1 ratio (57 FR 33878, July 1992); However, the more costly, inefficient 2:1 ratio is more commonly used.
- AAs are trained to **ASSIST physician** anesthesiologists and **lack the staffing flexibility** needed in today's dynamic healthcare delivery systems. First starts in the morning and complications may result in delays **or even fraudulent practice or billing with potential jeopardy for facilities**. One study found physician anesthesiologists did not meet TEFRA rules 35% for 2:1 and 99% for 3:1 ratios.[4]
- CMS has **denied AAs** billing for services as performed autonomously. A physician anesthesiologist who fails to meet medical direction TEFRA[1] rules **must bill using the AD modifier and lose revenue** of up to 50%.

1 Tax Equity and Fiscal Responsibility Act of 1982

2 Physician anesthesiologist

3 Staffing costs are based on salary only and provider staffing cost ratios are comparable when using median CRNA salary ($166,540) according to 2018 AANA Compensation & Benefits Survey. Salary costs for physician anesthesiologists are based on the 75th pctl salary ($420,284) according to HR Reported data as of March 29, 2018 form Salary.com

4 Epstein R, Dexter F. (2012). Influence of supervision ratios by anesthesiologist on first case starts and critical portions of anesthetics. Anesthesiology, 116(3):683-691.

AANA
AANA.com

Washington State Medical Association
Physician Driven, Patient Focused

June 28, 2021

Sherry Thomas
Health Systems Quality Assurance
Department of Health
101 Israel Road SE
Tumwater, WA 98501

RE: Anesthesiologist assistant sunrise review

Dear Ms. Thomas,

On behalf of the Washington State Medical Association (WSMA), I am writing in support of the Washington State Society of Anesthesiologists' (WSSA) proposal to license anesthesiologist assistants in Washington state. The education and training requirements outlined in the draft bill and application, as well as a shortage of anesthesia providers in our state, compel us to support this sunrise review.

Anesthesiologist assistants are currently practicing safely and effectively under the direction of physician anesthesiologists in 18 other states. Anesthesiologist assistants have advanced graduate degrees and are required to complete a comprehensive didactic and clinical program at the graduate school level. They are trained extensively in the delivery and maintenance of quality anesthesia care as well as advanced patient monitoring techniques. Under the guidance of a physician, anesthesiologist assistants administer drugs, obtain vascular access, apply and interpret monitors, establish and maintain a patient's airway, and assist with preoperative assessment.

The demonstrated need for highly-trained and qualified anesthesia providers working under the supervision of a physician anesthesiologist merits support. According to the Health Workforce Employment Data from the Workforce Training and Education Training Board, there are fewer than 1,800 anesthesia providers currently practicing in our state. Furthermore, WSSA recently conducted a survey that said almost 60% of practices in our state currently have positions open for anesthesiology providers. Of those practices, 70% of them have had the positions open for six months or longer.

Thank you for the opportunity to share our support for the licensure for anesthesiologist assistants. We appreciate your consideration. Should you have any follow-up questions, please

Seattle Office
2001 Sixth Avenue, Suite 2700
Seattle, WA 98121
o / 206.441.9762 *fax* / 206.441.5863
email / wsma@wsma.org

Olympia Office
1800 Cooper Point Road SW
Building 7, Suite A
Olympia, WA 98502
o / 360.352.4848 *fax* / 360.352.4303

contact WSMA Policy Analyst Billie Dickinson.

Sincerely,

Jeb Shepard
Director of Policy

Washington Academy of Anesthesiologist Assistants

October 1, 2021

Sherry Thomas
Anesthesiologist Assistant Sunrise Review Lead
Health Systems Quality Assurance
Washington State Department of Health
Re: Support of Draft Report to the Legislature in Favor of Certified Anesthesiologist Assistant Licensure

Dear Ms. Thomas,

The Washington Academy of Anesthesiologist Assistants (WAAAA) is pleased to support the draft report from the Department of Health recommending licensure for Certified Anesthesiologist Assistants (CAAs) in Washington. The WAAAA is a newly formed 501(c)(3) non-profit (pending) association organized to advance the CAA profession, to enhance the education and standards of anesthesia practice, to promote patient safety through the Anesthesia Care Team, and to provide a forum for CAA advocacy in the state of Washington.

CAAs are currently allowed to practice in nineteen jurisdictions. CAAs are recognized by the Centers of Medicare and Medicaid Services (CMS), Tri-care, and all major commercial insurance payors. CMS recognizes CAAs as qualified non-physician anesthesia providers, just like our CRNA counterparts.

The WAAAA appreciates the opportunity to comment on the draft report and respond to the Department's recommendations. We would also like to address some of the revisions being proposed.

<u>Recommendations for clarification</u>

The Department's first detailed recommendation was to clarify the definition of "supervision" to require the supervising anesthesiologist to be present in the operating suite, office, obstetrical unit, or other setting; and present in the operating room during induction of general or regional anesthesia or emergence from general anesthesia.

The WAAAA agrees with the recommendation to clarify the definition of supervision and recommends referencing "immediately available" in the statute. The American Society of Anesthesiologists (ASA) guidelines state *"A medically directing anesthesiologist is immediately available if s/he is in physical proximity that allows the anesthesiologist to re-establish direct*

contact with the patient to meet medical needs and any urgent or emergency clinical problems."[1] In addition to aligning with national guidelines, adding this clarification to the proposed legislation is consistent with the Medicare Conditions of Participation for anesthesia services (42 CFR § 482.52).

Alternative language recommended by the WAAAA:
"Supervision" means the availability of a physician anesthesiologist who can delegate, coordinate, direct, or consult, and to oversee the implementation of the anesthesiologist's intentions.

The Department's next recommendation was to narrow the scope of practice for CAAs and make the following key changes: authorize "assisting the supervising anesthesiologist" with the performance of general anesthesia and epidural, spinal, and intravenous regional anesthesia, rather than performing it; authorize "administering," rather than "ordering," medications; and remove the authority to order postoperative sedation or analgesia, oxygen or respiratory therapy, or medicine.

The WAAAA agrees that some additional clarification regarding the scope of practice defined in the legislation could be beneficial, and we recommend the following:

Authorizing "assisting" rather than "performing," and adding a definition for "assists."
"Assists" means the anesthesiologist assistant personally performs those duties and responsibilities delegated by the anesthesiologist. Delegated services must be consistent with the delegating physician's education, training, experience and active practice. Delegated services must be of the type that a reasonable and prudent physician would find within the scope of sound medical judgment to delegate.

Clarifying that CAAs do not have prescriptive authority by authorizing "administering" rather than "ordering" medications, and revising the sections on postoperative care. As such, we recommend striking Section 5 (c) (f) (w) (x) (y) and instead, inserting the following language:

"In consultation with supervising physician, order perioperative pharmaceutical agents, medications, fluids, oxygen therapy and respiratory therapy, to be used only at the facility where ordered, including but not limited to controlled substances, which may be administered prior to the co-signature of the supervising physician. The supervising physician may review and if required by the facility or institutional policy must cosign these orders in a timely manner."

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[1] See ASA's Definition of "Immediately Available" when Medically Directing available at https://www.asahq.org/standards-and-guidelines/definition-of-immediately-available-when-medically-directing

Finally, the Department recommends eliminating the advisory committee recommended in Section 3 of the proposed legislation because it is redundant. The WAAAA agrees with this recommendation.

Thank you again for the opportunity to provide feedback and clarity regarding the Department's recommendations.

The WAAAA appreciates your recommendation to support the licensure of CAAs in Washington. We are available to provide you with any additional information or resources that would help support the application.

Sincerely,

Sarah Brown, CAA
WAAAA President
president@washingtonaaa.org

AANA
American Association of
NURSE ANESTHESIOLOGY

October 1, 2021

VIA E-MAIL (anesthesiology-sunrise@doh.wa.gov)

Sherry Thomas, Policy Coordinator
Health Systems Quality Assurance
Department of Health

Dear Ms. Thomas:

The American Association of Nurse Anesthetists (AANA), which represents more than 59,000 nurse anesthetists (including Certified Registered Nurse Anesthetists (CRNAs) and student nurse anesthetists) nationwide, submits the following comments regarding the Department of Health's (Department) draft report recommending licensure of anesthesiologist assistants (AAs). We respectfully request that the Department reconsider this recommendation in view of the hundreds of comments requesting that the Department reject the Washington State Society of Anesthesiologists' (WSSA) sunrise application for AA licensure. We are extremely disappointed that the Department is recommending AA licensure given that AAs are an unproven provider that will not improve access to anesthesia services for the citizens of Washington, and the AA-anesthesiologist model is the costliest model of anesthesia care.

Difficult to Track Safety Data

The Department relies on the safety of AAs in its rationale for recommending AA licensure, stating that the lack of disciplinary actions in other states that license AAs shows that AAs are practicing safely. However, AAs must work under the direct supervision of an anesthesiologist, and it is not clear how complaints against AAs are tracked, particularly if the anesthesiologist is responsible for the AA's actions. For example, in the National Practitioner Data Bank (NPDB)[1], AAs do not have a dedicated licensure category. According to the NPDB, AAs may appear in "other" categories in which multiple unclassified practitioners are lumped together. This exemplifies the challenges of tracking AA adverse events and malpractice payments.

[1] https://www.npdb.hrsa.gov/topNavigation/aboutUs.jsp. The NPDB is a repository of information on medical malpractice payments and adverse actions related to health care practitioners. This database prevents practitioners from moving state to state without disclosure or discovery of previous damaging performance.

222 South Prospect Avenue
Park Ridge, IL 60068

Phone 847.692.7050
Toll-free 855.526.2262

Safety of AAs is Unproven

AAs are an unproven provider because they do not have a track-record of safety. In contrast, there is overwhelming evidence that CRNAs provide extremely safe, cost-effective anesthesia care.[2, 3] The cost-effectiveness directly relates to access to anesthesia care for patients. CRNAs have been, since their inception, professionals who are acknowledged by the surgeons with whom they practice as being experts regarding anesthesia.

AAs have a limited history as a provider, and their numbers are too small to track safety or efficacy. The WSSA cited in its sunrise application a 2018 study [4] (the "Sun Study") to conclude that AAs are safe; however, as we stated in our comment letter dated July 16, 2021, the population studied was highly restricted (older adults in non-opt-out states[5] in higher volume hospitals and procedure types) limiting the study's generalizability. The sample size fell short of the size needed to measure differences in quality by provider type, especially for AA cases. Further, the outcomes analyzed in the Sun Study were not anesthesia specific, and the mortality rate for AA cases was based on overall inpatient surgical cases and not necessarily related to anesthesia-related complications.

The WSSA's reliance on the Sun Study to support the safety of AAs is faulty. The Sun Study reviewed cases between 2004 and 2011, and only in non-opt out states. The number of AAs practicing during this period was significantly lower than it is today because there were fewer states that recognized AAs and fewer AA programs. In addition, any AAs practicing in opt-out states were excluded. If the Department is relying on this study to support the safety of AAs, we encourage the Department to seek an independent review of the study's methods, including exclusion criteria, risk adjustment approach, and relevance of the outcomes.

AAs are limited by their training and licensure to providing clinical support to anesthesiologists and may not practice without direct anesthesiologist supervision. It is virtually impossible to assess the quality and safety of AAs because they cannot work apart from anesthesiologists. AAs are not required to have any prior healthcare education or experience before they begin their AA educational programs, and unlike CRNAs, AAs have not learned to assess and treat a broad range of health problems before beginning anesthesia training. All of these factors contribute to the safety of a provider, and AAs do not measure up against the proven safety of CRNAs.

Washington should focus on growing the anesthesia providers already providing safe, high-quality anesthesia care in the state rather than introducing an unproven provider. Without evidence that AAs are safe, AA licensure should be rejected.

---

[2] Dulisse, B., Cromwell, J. "No Harm Found When Nurse Anesthetists Work Without Supervision by Physicians." *Health Affairs.* August 2010. 2010(29): 1469-1475.

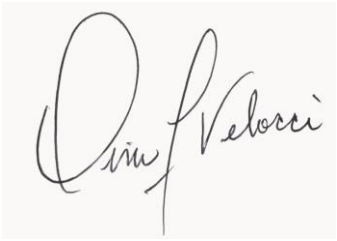
[3] Hogan, P., Seifert, R., Moore, C., Simonson, B. "Cost Effectiveness Analysis of Anesthesia Providers." *Journal of Nursing Economic$.* May/June 2010. 28, No. 3. 159-169.

[4] Eric C. Sun et. al, "Anesthesia Care Team Composition and Surgical Outcomes." Anesthesiology 2018.

[5] "Non-opt out" states refers to the states that have not "opted-out" of the Medicare Part A supervision requirements for CRNAs.

Please do not hesitate to contact Anna Polyak at 847-655-1131 or apolyak@aana.com if you have any questions or require further information.

Sincerely,



Dina Velocci, DNP, CRNA, APRN
AANA President

Dear Sunrise Review Panel Member:

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I urge you to reconsider and reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs).

Healthcare Costs

To begin, the first round of comments demonstrated through publications, that AAs will not decrease healthcare costs in Washington. In fact, literature suggests they will result in the restriction of access while increasing costs for those having to undergo surgical procedures. The medical-direction model (appropriately required in the Sunrise Review Bill due to the restricted scope because of insufficient training) mandates excessive manpower- five providers for four patients. Because Washington State already licenses providers who practice to their full scope, no reason exists to have an excess available simply to “monitor” patients from various wings of a hospital.

Anesthesia models of care are determined by hospital bylaws, not legislation. The medical-

direction model is the most expensive. Even with the excess staffing, Childers and Maggard-Gibbons (2018) found a 2014 cross-sectional analysis demonstrating mean cost of operating room time in California's acute care hospitals was $36-$37 a minute. Epstein and Franklin (2012) demonstrated a delay in surgical cases with a medical-direction ratio of 1:2- 35% of the time! It's important to note that the addendums suggest a 1:4 supervision ratio, which indicates even further postponements in care. The financial impact is nothing short of remarkable when surgeries and procedures are delayed because of the supervising physician anesthesiologist is busy elsewhere. Ask any surgeon working in an anesthesia care team model if they enjoy waiting for the attending anesthesiologist to begin their surgical case. The model does not decrease costs or increase access.

When considering healthcare costs, I ask the DOH to review the research regarding anesthesia practice models. The extensive costs that patients have to endure and the impact needless delays have on our healthcare system is profound- all in the name of "medical direction." Who benefits from that anesthesia model? Certainly not the patients,

healthcare systems (other than physician groups), insurance companies, Medicare or Medicaid's

Anesthesia Cost-Effective Solution

CRNAs and physician anesthesiologists work in a collaborative model in several large facilities across the state. They care for patients side-by-side, each in their own surgical cases. In a collaborative model, there are no surgical delays due to meeting TEFRA requirements- these requirements that, if met, allow physician anesthesiologists to bill for 50% of the case's anesthesia services, even though they are not the primary practitioners providing the anesthetic. Unlike the medical-direction model mandated for the AAs, patients don't have to spend endless amounts of time, waiting for the physician anesthesiologist to enter a room to remove a breathing tube in an awake patient. Under the care of skilled, independent providers, patients are not placed at risk; the provider at the head of their bed has extensive experience managing cardiac and respiratory emergencies. When seconds count, Washingtonians deserve anesthesia providers who know how to save lives, not wait to be directed for interventions in a crisis. They deserve independent,

critical thinking, compassionate anesthesia providers.

Medical-direction with AAs, while being the most expensive model, also has impact on patient wellbeing. Studies have shown that, in this model, there are delays. Consider that vulnerable patients are often lying on a cold, narrow operating room table, unmedicated and scared, waiting for the physician anesthesiologist in order to induce anesthesia. During surgeries, patients will have to wait for the physician anesthesiologist for interventions while they are unconscious, hemodynamically unstable and vulnerable. Emergency, life-saving Cesarean sections would have to be delayed, placing the mother and baby at risk. Patients would have to wait, aware of their circumstances, for the supervising anesthesiologist, in order to have their breathing tube removed. When considering practice profile of AAs, I ask the DOH to reflect on patient expectations of the surgical experience. Would you want to wait an hour to begin your anesthesia because AA cannot provide comfort because the supervising anesthesiologist is inducing other patients? Do you want to wait fifteen minutes, awake, with a breathing tube after surgery, waiting for the supervising anesthesiologist, for it to be

removed? Do you want the interventions to keep you, or your family, safe to be from extensive experience or from a telephone call taken from across the hospital, while you are in the most vulnerable of circumstances?

Anesthesia is only as safe as the trained provider administering it. A blanket statement of safety regarding an unproven provider is insulting to those who dedicate their lives to the science and art of patient care and anesthesia. Anesthesia, given through untrained hands, can have devastating results.

Lack of public disclosures or closed claims does not demonstrate a safety profile I would wish to care for my community, family or colleagues. Washingtonians deserve the best care available- AAs do not reflect the healthcare culture for which we are known. No peer-reviewed articles that demonstrate safety exist. Only one is sited- ONE. This study compared a final sample consisted of 421,230 surgical cases in which the care team consisted of a physician anesthesiologist and a nurse anesthetist, and 21,868 cases in which the care team consisted of a physician anesthesiologist and an anesthesiologist assistant. One article, with manipulated,

extrapolated data, does not equate to a safe provider. The sample size differences would equate to judging ones's marathon pace by the first mile alone- it simply doesn't compare.

Access for All

Finally, because AAs cannot practice without anesthesiologist supervision, AAs cannot practice in rural areas where CRNAs working without anesthesiologist involvement are the primary providers of anesthesia care throughout the community. AAs can ONLY practice where physician anesthesiologists practice, which greatly limits their utilization. AAs cannot help solve problems of inadequate access to anesthesia care in rural and underserved communities. If for any reason an AA's supervising anesthesiologist is not available, off-site, on vacation, or simply home for the day, the AA may not provide anesthesia care- or any patient care. Surgical cases would be delayed. AAs cannot be utilized to intervene during COVID pandemic, having no ICU experience or clinical requirement in any other aspect of patient care. The AA anesthesiologist-driven mode of practice, therefore, is inflexible and fails to adequately meet

the needs of patients, hospitals, ambulatory surgical centers, or other healthcare settings.

Increased access, along with excellent, safe anesthesia care that CRNAs provide have been repeatedly demonstrated in peer-reviewed studies published in prominent journals. It makes no sense to authorize AAs, a less qualified anesthesia provider that can only work under the direct supervision of anesthesiologists. They can't be used in any area where anesthesiologists don't practice, such as many rural locations. To best increase access and maintain the safest care for Washingtonians, the WSSA and WANA should work in concert to promote an anesthesia model that places patients and outcomes, not billing revenue, as the main driver of anesthesia care.

Please reject the licensure of anesthesia assistants.

Best regards,

Ashley E. Fedan

References:

Childers, C. P., & Maggard-Gibbons, M. (2018). Understanding Costs of Care in the Operating Room. *JAMA Surg, 153*(4). doi:10.1001/jamasurg.2017.6233

Epstein, R. H. & Dexter, F. (2012). Influence of Supervision Ratios by Anesthesiologists on First-case Starts and Critical Portions of Anesthetics. *Anesthesiology,* 116, 683–691. https://doi.org/10.1097/ALN.0b013e318246ec24

Dear Ms. Thomas:

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I am extremely disappointed that the Department of Health is recommending anesthesiologist assistant licensure in its draft sunrise report. The public will not be protected by licensing anesthesiologist assistants (AAs). I urge you to change your recommendation and reject licensure of AAs.

The administration of anesthesia, including general anesthesia, has inherent risks to patients. These risks include pain, nausea and vomiting, laryngeal damage, anaphylaxis to anesthetic agents, cardiovascular collapse, respiratory depression, and dizziness. We must ensure that all anesthesia providers are safe to practice and are equipped with the skills to respond to medical emergencies. The administration of anesthesia is safe because of the skillset and training of the provider, their ability to immediately intervene to maintain patient stability, and continuously evaluate the interventions to maintain patient safety. A "simple anesthetic" does not exist.

AA education and training does not ensure the critical thinking skills necessary to respond to immediate patient emergencies. For example, there is no requirement for AAs to have any patient care experience prior to beginning their training. AAs do not have a broad foundation to reference when a patient's condition deteriorates. When life and death decisions are required, the operating surgeon will be forced to step in until the anesthesiologist, who is caring for other patients under anesthesia throughout a hospital, becomes available. This situation places the patient at immense risk at their most vulnerable of moments. Results will negatively impact the patient, provider, surgeon, and hospital.

Citizens of Washington State deserve proven, safe providers. The quality of care that AAs provide remains unknown; no meaningful research data exists concerning AA anesthesia quality and safety. The anesthesia care team model, which their supervision is mandated, is inefficient, costly, and concerning their lack of experience, would leave patients vulnerable. In contrast, the excellent, safe anesthesia care that CRNAs offer with associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.

Washington state must support its existing, high quality anesthesia providers, CRNAs and physician anesthesiologists. Licensure for a narrowly trained provider with limited usefulness will not be beneficial in many healthcare settings, especially during our current COVID crisis. CRNAs are prepared to be instrumental in providing access to quality care while decreasing healthcare costs. Please reject licensure for anesthesiologist assistants.

Sincerely,

Ryan Mills

Dear Ms. Thomas:

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I am extremely disappointed that the Department of Health is recommending anesthesiologist assistant licensure in its draft sunrise report. The public will not be protected by licensing anesthesiologist assistants (AAs). I urge you to change your recommendation and reject licensure of AAs.

The administration of anesthesia, including general anesthesia, has inherent risks to patients. These risks include pain, nausea and vomiting, laryngeal damage, anaphylaxis to anesthetic agents, cardiovascular collapse, respiratory depression, and dizziness. We must ensure that all anesthesia providers are safe to practice and are equipped with the skills to respond to medical emergencies. The administration of anesthesia is safe because of the skillset and training of the provider, their ability to immediately intervene to maintain patient stability, and continuously evaluate the interventions to maintain patient safety. A "simple anesthetic" does not exist.

AA education and training does not ensure the critical thinking skills necessary to respond to immediate patient emergencies. For example, there is no requirement for AAs to have any patient care experience prior to beginning their training. AAs do not have a broad foundation to reference when a patient's condition deteriorates. When life and death decisions are required, the operating surgeon will be forced to step in until the anesthesiologist, who is caring for other patients under anesthesia throughout a hospital, becomes available. This situation places the patient at immense risk at their most vulnerable of moments. Results will negatively impact the patient, provider, surgeon, and hospital.

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Washington state must support its existing, high quality anesthesia providers, CRNAs and physician anesthesiologists. Licensure for a narrowly trained provider with limited usefulness will not be beneficial in many healthcare settings, especially during our current COVID crisis. CRNAs are prepared to be instrumental in providing access to quality care while decreasing healthcare costs. Please reject licensure for anesthesiologist assistants.

Sincerely,

Erin E. Mills, CRNA, MSNA, RN, BSN

(Please read the personal note at the end)

Dear Sunrise Review Panel Member:

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I urge you to reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs). AAs do not improve access to care in Washington; in fact, there is reason to believe they will result in restricting access and driving up costs. AAs are narrowly trained and cannot practice without a licensed anesthesiologist. Finally, AAs are an unproven provider with no peer-reviewed studies that prove the safety of AAs.

Certified Registered Nurse Anesthetists (CRNAs) are certified anesthesia experts independently licensed to practice in all 50 states and the District of Columbia. Because of their extensive education and training, CRNAs are permitted by federal and state laws and regulations to provide every type of anesthesia service to patients without the involvement or presence of a physician anesthesiologist. All research studies on anesthesia safety and cost-effectiveness conducted in the last 20 years confirm that CRNAs provide the safest, most cost-effective anesthesia care to patients.

In contrast, AAs can only practice in 15 states plus the District of Columbia. They are limited by their training and licensure to providing clinical support to anesthesiologists and may not practice “apart from the supervision of an anesthesiologist,” according to the American Academy of Anesthesiologist Assistants (AAAA). Because AAs are required to be directly supervised by an anesthesiologist, the AA/anesthesiologist team is one of the costliest anesthesia delivery models with no scientific evidence of increased patient safety.

Because AAs cannot practice without anesthesiologist supervision, AAs do not practice in rural areas where CRNAs working without anesthesiologist involvement are the primary providers of anesthesia care. In fact, CRNAs are the only anesthesia provider in 72% of Washington’s rural hospitals. AAs, in contrast, can only practice where anesthesiologists practice, which greatly limits their utilization. AAs, therefore, can’t help solve problems of inadequate access to anesthesia care in rural and underserved communities.

If for any reason an AA’s supervising anesthesiologist is not available, off-site, on vacation, or simply home for the day, the AA may not provide anesthesia care. The AA anesthesiologist-driven mode of practice, therefore, is inflexible and fails to adequately meet the needs of patients, hospitals, ambulatory surgical centers, or other healthcare settings.

While nurse anesthesia educational programs graduate nurse anesthetists prepared for autonomous practice, the AA program curriculum is characterized by training that only allows them to assist anesthesiologists in technical functions.

Because CRNAs do not need to practice with an anesthesiologist, they are much more cost effective than AAs. With an AA, the need exists to educate and use two providers – the

supervising anesthesiologist and the AA – to provide anesthesia care to one patient. With a CRNA, only that individual is needed to provide total anesthesia care to the patient. Essentially, compared with the anesthesiologist-AA staffing arrangement, one CRNA can provide the care of two providers.

AAs are an unproven provider. No peer-reviewed studies in scientific journals have been published regarding the quality of care of AA practice or AA anesthesia outcomes. The quality of care that AAs provide is unproven, as there is no meaningful research data concerning AA anesthesia safety. In contrast, the excellent, safe anesthesia care that CRNAs provide, and associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.

It makes no sense to authorize AAs, a less qualified anesthesia provider that can only work with anesthesiologists and can't be used in any area where anesthesiologists don't practice, such as many rural locations. Please reject the application for licensure of anesthesiologist assistants.

Sincerely,

Tracy Casper MSN, ARNP, CRNA
Certified Registered Nurse Anesthesiologist

On a personal note, I have been providing anesthesia for 28 years. I am a Nurse Anesthetist, practiced in Florida for the first years of my career. AA's, (Anesthesia Assistant) were able to work in Florida at some point but I never worked directly with them. I interviewed at a facility in Vero Beach and learned that an Anesthesiologist left after working with an AA. She did not feel comfortable supervising him.

I know that patient care will suffer, costs will become inflexible, and staffing will also suffer. The quality of anesthesia care, comparing quality between MD and Nurse Anesthesia care, has been studied and found to be equal, so that is not even as issue. The cost of an AA will always be dependent on the presence of an Anesthesiologist; thus, one can only calculate the expense. Nurse Anesthetists can function separate from an Anesthesiologist, thus the need to hire/pay for ONE provider, not two. Do not be fooled by the rhetoric espoused by the supporters of AA's. Anesthesiologists have long had an agenda to denigrate and criticize us (Nurse Anesthetist) while working alongside of us. We work well together, and we work well separate. It all only depends on bylaws from specific facilities or hospitals.

If you would like to speak with me personally, please call me. I would feel privileged to speak with you about this issue. My personal number is 561-313-6149.

Tracy Casper, CRNA

As a certified registered nurse anesthetist (CRNA), I urge you to REJECT the sunrise review application regarding licensure for anesthesiologist assistants (AAs) in the state of Washington. AAs DO NOT improve access to care in Washington and are CLEARLY being utilized by the American Association of Anesthesiologists as a trojan horse in a battle that does not have the interest of patients or their access to care at its heart. In order to appreciate this, the history of CRNAs and MD anesthesiologists must be understood. At a superficial glance it appears that their objective is to increase access to care. However, I believe that their true intention is to decrease and hinder CRNA practice while utilizing patient access as their motive. This political plight would clearly incentivise the replacement of CRNAs with Anesthesiologists and their AAs.

Unfortunately, patient safety is placed at risk. AAs are an unproven provider with no peer-reviewed studies that prove the safety of AAs. In comparison, Certified Registered Nurse Anesthetists are certified anesthesia experts independently licensed to practice in all 50 states and the District of Columbia. Because of their extensive education and training, CRNAs are permitted by federal and state laws and regulations to provide every type of anesthesia service to patients without the involvement or presence of a physician anesthesiologist. All research studies on anesthesia safety and cost-effectiveness conducted in the last 20 years confirm that CRNAs provide the safest, most cost-effective anesthesia care to patients.
In contrast, AAs can only practice in 15 states plus the District of Columbia. They are limited by their training and licensure to providing clinical support to anesthesiologists and may not practice “apart from the supervision of an anesthesiologist,” according to the American Academy of Anesthesiologist Assistants (AAAA). Because AAs are required to be directly supervised by an anesthesiologist, the AA/anesthesiologist team is one of the costliest anesthesia delivery models with no scientific evidence of increased patient safety.

In regards to access to care, because AAs cannot practice without anesthesiologist supervision, AAs do not practice in RURAL AREAS where CRNAs working without anesthesiologist involvement are the PRIMARY providers of anesthesia care. In fact, CRNAs are the only anesthesia provider in 72% of Washington’s rural hospitals. AAs, in contrast, can only practice where anesthesiologists practice, which greatly limits their utilization. AAs, therefore, can’t help solve problems of inadequate access to anesthesia care in rural and underserved communities.If for any reason an AA’s supervising anesthesiologist is not available, off-site, on vacation, or simply home for the day, the AA may not provide anesthesia care. The AA anesthesiologist- driven mode of practice, therefore, is inflexible and fails to adequately meet the needs of patients, hospitals, ambulatory surgical centers, or other healthcare settings.

While nurse anesthesia educational programs graduate nurse anesthetists prepared for autonomous practice, the AA program curriculum is characterized by training that ONLY allows them to assist anesthesiologists in technical functions. On the other hand, CRNAs do not need to practice with an anesthesiologist and are ready to practice as an independent anesthesia provider as soon as they graduate from an accredited program. With an AA, the need exists to educate and use two providers – the supervising anesthesiologist and the AA – to provide anesthesia care to one patient. With a CRNA, only that individual is needed to provide total

anesthesia care to the patient. Essentially, compared with the anesthesiologist-AA staffing arrangement, one CRNA can provide the care of two providers.
AAs are an unproven provider. No peer-reviewed studies in scientific journals have been published regarding the quality of care of AA practice or AA anesthesia outcomes. The quality of care that AAs provide is unproven, as there is no meaningful research data concerning AA anesthesia safety. In contrast, the excellent, safe anesthesia care that CRNAs provide and associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals. Licensing AAs, a less qualified anesthesia provider, that can only work with anesthesiologists and can't be used in any area where anesthesiologists don't practice, such as MOST rural locations is DANGEROUS. Please REJECT the application for licensure of anesthesiologist assistants in the state of WA.

Sincerely,
Joel Castrellon, CRNA

Dear Sunrise Review Panel Member:

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I urge you to reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs). AAs do not improve access to care in Washington; in fact, there is reason to believe they will result in restricting access and driving up costs. AAs are narrowly trained and cannot practice without a licensed anesthesiologist. Finally, AAs are an unproven provider with no peer-reviewed studies that prove the safety of AAs.

Certified Registered Nurse Anesthetists (CRNAs) are certified anesthesia experts independently licensed to practice in all 50 states and the District of Columbia. Because of their extensive education and training, CRNAs are permitted by federal and state laws and regulations to provide every type of anesthesia service to patients without the involvement or presence of a physician anesthesiologist. All research studies on anesthesia safety and cost-effectiveness conducted in the last 20 years confirm that CRNAs provide the safest, most cost-effective anesthesia care to patients.

In contrast, AAs can only practice in 15 states plus the District of Columbia. They are limited by their training and licensure to providing clinical support to anesthesiologists and may not practice "apart from the supervision of an anesthesiologist," according to the American Academy of Anesthesiologist Assistants (AAAA). Because AAs are required to be directly supervised by an anesthesiologist, the AA/anesthesiologist team is one of the costliest anesthesia delivery models with no scientific evidence of increased patient safety.

Because AAs cannot practice without anesthesiologist supervision, AAs do not practice in rural areas where CRNAs working without anesthesiologist involvement are the primary providers of anesthesia care. In fact, CRNAs are the only anesthesia provider in 72% of Washington's rural hospitals. AAs, in contrast, can only practice where anesthesiologists practice, which greatly limits their utilization. AAs, therefore, can't help solve problems of inadequate access to anesthesia care in rural and underserved communities.

If for any reason an AA's supervising anesthesiologist is not available, off-site, on vacation, or simply home for the day, the AA may not provide anesthesia care. The AA anesthesiologist driven mode of practice, therefore, is inflexible and fails to adequately meet the needs of patients, hospitals, ambulatory surgical centers, or other healthcare settings. While nurse anesthesia educational programs graduate nurse anesthetists prepared for autonomous practice, the AA program curriculum is characterized by training that only allows them to assist anesthesiologists in technical functions.

Because CRNAs do not need to practice with an anesthesiologist, they are much more cost effective than AAs. With an AA, the need exists to educate and use two providers – the supervising anesthesiologist and the AA – to provide anesthesia care to one patient. With a CRNA, only that individual is needed to provide total anesthesia care to the patient. Essentially, compared with the anesthesiologist-AA staffing arrangement, one CRNA can provide the care of two providers.

AAs are an unproven provider. No peer-reviewed studies in scientific journals have been published regarding the quality of care of AA practice or AA anesthesia outcomes. The quality of care that AAs provide is unproven, as there is no meaningful research data concerning AA anesthesia safety. In contrast, the excellent, safe anesthesia care that CRNAs provide and associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.

It makes no sense to authorize AAs, a less qualified anesthesia provider that can only work with anesthesiologists and can't be used in any area where anesthesiologists don't practice, such as many rural locations.

Please reject the application for licensure of anesthesiologist assistants.

Sincerely,

Jacob Beckstrand, CRNA, PeaceHealth St. John Medical Center

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I am extremely concerned that the Department of Health (DOH) is recommending anesthesiologist assistant (AA) licensure in its draft sunrise report. The public will not be protected, but instead put at greater risk by licensing anesthesiologist assistants (AAs). I urge you to change your recommendation and reject the licensure of AAs.

The administration of anesthesia, including general anesthesia, has inherent risks to patients. These risks include pain, nausea and vomiting, laryngeal damage, anaphylaxis to anesthetic agents, cardiovascular collapse, respiratory depression, and dizziness. The Department of Health must ensure that all anesthesia providers are safe to practice and are equipped with the extremely important skills to respond to medical emergencies not only during surgery but when patients come in as traumas and when patients code on the floor. The current administration of anesthesia remains safe because of the skills and extent of training of the providers, their ability to immediately intervene to maintain patient stability, and continuously evaluate the interventions to maintain patient safety.

AA education and training does NOT ensure the critical thinking skills necessary to respond to immediate patient emergencies. For example, there is no requirement for AAs to have any patient care experience prior AT ALL to be accepted to an AA program and begin their training. AAs do not have a broad foundation/critical care background to reference when a patient's condition deteriorates. When life and death decisions are required, the surgeon performing the procedure will be forced to step in until the anesthesiologist, who is caring for other patients under anesthesia throughout a hospital, becomes available. This situation places the patient at immense risk at their most vulnerable moments. Detrimental outcomes that will negatively impact the patient, provider, surgeon, and hospital. This is a stark contrast to how CRNAs can provide impeccable care in these situations to their background in critical care as well as their superior training in independently providing anesthesia.

The citizens of Washington State deserve safe, proven providers. The quality of care that AAs provide remains unknown. No meaningful research data exists concerning AA anesthesia and quality and safety outcomes. The anesthesia care team model, which is the only anesthesia model AAs are able to practice under, is inefficient, costly, and leaves patients vulnerable due to their lack of training.

In contrast, the proven, excellent anesthesia care that CRNAs offer with safe anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals. Washington state MUST continue to support its existing, high quality anesthesia providers: CRNAs and physician anesthesiologists. Licensure for a narrowly trained provider with limited usefulness will not be beneficial in many healthcare settings, especially during our current COVID crisis. Currently, with a complete halt of all non-emergent surgical cases, we as CRNAs have offered our skillset as prior critical care ICU RNs to assist with the COVID surge in the ICUs as well as providing our advance skill set in anesthesia as an ARNP CRNA for assistance to the MD/ARNP critical care providers. AAs simply cannot provide this cross over care as we can, nor do they even remotely have any set of background or credentials to provide these skills nor credentials as a sole provider and would prove useless in this situation. CRNAs

are prepared to be instrumental in providing access to quality care while decreasing healthcare costs and have truly stepped up to help the burden of the crisis care that is occurring across WA.

Thank you for your consideration in this matter.

Again, I humbly urge you to reject licensure for anesthesiologist assistants in the state of Washington.

Respectfully,
Dr. Jessie Bozelka, DNP, CRNA

CRNA VS. AA

Certified Registered Nurse Anesthetists

AUTONOMOUS, safe, cost-effective—ensure access to care

CRNAs are educated to be an **AUTONOMOUS** anesthesia provider and are qualified to make **INDEPENDENT** judgements regarding all aspects of anesthesia care. CRNAs and anesthesiologists can work **INDEPENDENT** of one another or together.

The most cost-effective anesthesia delivery model is a CRNA working **AUTONOMOUSLY**. A CRNA working **AUTONOMOUSLY** can provide the care that requires two providers when the anesthesiologist-AA model is used.

CRNAs work in urban and rural areas, and across all types of practice settings. CRNAs working without anesthesiologist involvement are the primary providers of anesthesia care in rural areas.

CRNAs are **AUTONOMOUS** within a patient care team regardless of the composition of that team. CRNAs provide high quality anesthesia care with or without physician oversight.

CRNAs provide quality care with or without physician oversight. When working in the anesthesia care team, if there is no supervision, the facility simply bills exclusive of the anesthesiologist for the procedure (QZ vs. medical direction).

CRNAs are educated and trained to work with or without physician involvement and are capable of high-level **AUTONOMOUS** function and judgement.

Applicants for nurse anesthesia programs have acquired extensive clinical experience in a variety of areas such as coronary, respiratory, postanesthesia, and surgical intensive care units before they begin their nurse anesthesia programs.

CRNAs receive 7-8 ½ years of formal education and preparation, from commencement of the professional education in nursing to graduation from nurse anesthesia school. During the course of their education, CRNAs will typically have acquired, on average, 8,636 hours of clinical patient care experience.

Anesthesiologist **ASSISTANTS**

DEPENDENT, costly—do not improve access to care

AAs are trained to be an **ASSISTANT, DEPENDENT** practitioner and cannot work autonomously; they can only work under the direct supervision of an anesthesiologist[1].

AAs are **DEPENDENT** practitioners that must work with a supervising anesthesiologist; therefore, it takes two providers to provide anesthesia care to one patient, which is not a cost-effective model of care.

AAs are **DEPENDENT** practitioners who cannot expand access to care. AAs cannot help solve problems of inadequate access to anesthesia care in rural and underserved communities.

AAs are **DEPENDENT** practitioners who are not trained to make autonomous decisions when there are lapses in supervision[2].

AAs are **DEPENDENT** practitioners that create an environment for Medicare fraud. AAs cannot provide care without direct supervision, leading to possible unauthorized independent practice.

AAs are **DEPENDENT** providers who can only take delegated orders from an anesthesiologist.

AA programs do not require any nursing, medical, anesthesia or healthcare education, experience, licensure, or certification for admission into an AA program.

Clinical hours for AA programs include experiences such as learning to do physicals, taking patient histories, training and certification processes for life support training, and other learning experiences that a licensed professional RN has already mastered prior to nurse anesthesia program entry. During their AA program, AAs students average 2,600 hours of clinical anesthesia education.

1 As used in this document, "supervision" also refers to "medical direction" under TEFRA (Tax Equity and Fiscal Responsibility Act of 1982).

2 "Lapse in supervision" is the inability of a supervising anesthesiologist in an anesthesia care team to be physically present at "bedside" during required (most important) aspects of a case as specified under TEFRA.

AANA

AANA.com

AAs Anesthesiologist ASSISTANTS

INFLEXIBLE STAFFING STRUCTURE POTENTIAL REDUCED REVENUE

AAs are **only** able to provide anesthesia care **under the direct supervision** of a physician anesthesiologist.

Physician anesthesiologists can only bill for AAs when medical direction criteria are met.

AAs CANNOT work Autonomously

AAs CANNOT Collaborate with Surgeons or Proceduralists

Medical Direction (QK) TEFRA[1] Compliance Capability

(2:1 Ratio)

AA + ANES[2]

12 + 6

Staffing Cost[3]

4.52M

Failed Medical Direction (QK) defer to Supervision (AD) Billing

(3:1 Ratio)

AA + ANES[2]

12 + 4

Staffing Cost[3]

3.68M

Significant Risk For Medicare Fraud

Reduced Revenue

- **AAs must work** in an Anesthesia Care Team Model generally billed under Medical Direction billing model with no more than a 4:1 ratio (57 FR 33878, July 1992); However, the more costly, inefficient 2:1 ratio is more commonly used.
- AAs are trained to **ASSIST physician** anesthesiologists and **lack the staffing flexibility** needed in today's dynamic healthcare delivery systems. First starts in the morning and complications may result in delays **or even fraudulent practice or billing with potential jeopardy for facilities**. One study found physician anesthesiologists did not meet TEFRA rules 35% for 2:1 and 99% for 3:1 ratios.[4]
- CMS has **denied AAs** billing for services as performed autonomously. A physician anesthesiologist who fails to meet medical direction TEFRA[1] rules **must bill using the AD modifier and lose revenue** of up to 50%.

1 Tax Equity and Fiscal Responsibility Act of 1982

2 Physician anesthesiologist

3 Staffing costs are based on salary only and provider staffing cost ratios are comparable when using median CRNA salary ($166,540) according to 2018 AANA Compensation & Benefits Survey. Salary costs for physician anesthesiologists are based on the 75th pctl salary ($420,284) according to HR Reported data as of March 29, 2018 form Salary.com

4 Epstein R, Dexter F. (2012). Influence of supervision ratios by anesthesiologist on first case starts and critical portions of anesthetics. Anesthesiology, 116(3):683-691.

AANA
AANA.com

WHAT (STATE) LAWMAKERS NEED TO KNOW ABOUT

CRNAs vs. AAs

There is no shortage of Certified Registered Nurse Anesthetists (CRNAs) or physician anesthesiologists to provide safe, high-quality anesthesia care to patients in (State). Currently, anesthesiologist assistants (AAs) are not a recognized healthcare provider in (State) for ***many reasons***.

CRNAs Independent, safe, cost-effective—ensure access to care	AAs Dependent, costly—do not improve access to care
CRNAs...and anesthesiologists ***can work independent of one another OR together*** by law to ensure patients access to surgical, obstetrical, emergency and pain management services in rural and urban locations across the state.	**AAs...*cannot work independently;*** they can ***only work under the direct supervision[1] of an anesthesiologist,*** dramatically limiting ***where*** and ***when*** they can provide patient care.
CRNAs...are educated and trained to ***work independently*** (without an anesthesiologist).	**AAs...**are educated and trained to ***assist*** anesthesiologists.
CRNAs...*may* work in an anesthesia care team (with an anesthesiologist), but ***are not required*** to do so.	**AAs...*must*** work in an anesthesia care team with an anesthesiologist.
CRNAs...working in a care team will ***continue to provide patient care*** if there is a ***lapse in supervision.***[2]	**AAs...*legally cannot provide patient care*** if there is a ***lapse in supervision.***
CRNAs...provide high quality care regardless of whether anesthesiologist supervision requirements are met.[1] In such cases, the facility simply bills ***exclusive of the anesthesiologist*** for the procedure (***QZ vs. medical direction***).	**AAs...*cannot provide care without direct supervision***, leading to possible ***case delays*** or even ***unauthorized independent practice, regulatory violations, and accreditation jeopardy for facilities***.

Other CRNA Advantages

Since 2000, multiple research studies confirm that CRNAs are ***safe, high-quality*** anesthesia providers—***as safe as physician anesthesiologists.***

The ***most cost-effective anesthesia delivery model*** is a CRNA working independently; the most expensive is one anesthesiologist supervising another provider.

CRNAs: Ensuring patients access to safe, cost-effective anesthesia care

1 As used in this document, "supervision" also refers to "medical direction" under TEFRA (Tax Equity and Fiscal Responsibility Act of 1982).

2 "Lapse in supervision" is the inability of a supervising anesthesiologist in an anesthesia care team to be physically present at "bedside" during required (most important) aspects of a case as specified under TEFRA.

Logo Here

(State) Association of Nurse Anesthetists

STATEwebsite.org

Dr. Julie Anne Chinnock, ND, MPH, CRNA
3800 Aurora Ave N, #360,
Seattle, WA 98103

Dear Sunrise Review Panel Member:

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I urge you to reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs). AAs do not improve access to care in Washington; in fact, there is reason to believe they will result in restricting access and driving up costs. AAs are narrowly trained and cannot practice without a licensed anesthesiologist. Finally, AAs are an unproven provider with no peer-reviewed studies that prove the safety of AAs.

Certified Registered Nurse Anesthetists (CRNAs) are certified anesthesia experts independently licensed to practice in all 50 states and the District of Columbia. Because of their extensive education and training, CRNAs are permitted by federal and state laws and regulations to provide every type of anesthesia service to patients without the involvement or presence of a physician anesthesiologist. All research studies on anesthesia safety and cost-effectiveness conducted in the last 20 years confirm that CRNAs provide the safest, most cost-effective anesthesia care to patients.

In contrast, AAs can only practice in 15 states plus the District of Columbia. They are limited by their training and licensure to providing clinical support to anesthesiologists and may not practice "apart from the supervision of an anesthesiologist," according to the American Academy of Anesthesiologist Assistants (AAAA). Because AAs are required to be directly supervised by an anesthesiologist, the AA/anesthesiologist team is one of the costliest anesthesia delivery models with no scientific evidence of increased patient safety.

Because AAs cannot practice without anesthesiologist supervision, AAs do not practice in rural areas where CRNAs working without anesthesiologist involvement are the primary providers of anesthesia care. In fact, CRNAs are the only anesthesia provider in 72% of Washington's rural hospitals. AAs, in contrast, can only practice where anesthesiologists practice, which greatly limits their utilization. AAs, therefore, can't help solve problems of inadequate access to anesthesia care in rural and underserved communities.

If for any reason an AA's supervising anesthesiologist is not available, off-site, on vacation, or simply home for the day, the AA may not provide anesthesia care. The AA anesthesiologist-driven mode of practice, therefore, is inflexible and fails to adequately meet the needs of patients, hospitals, ambulatory surgical centers, or other healthcare settings.
While nurse anesthesia educational programs graduate nurse anesthetists prepared for autonomous practice, the AA program curriculum is characterized by training that only allows them to assist anesthesiologists in technical functions.

Because CRNAs do not need to practice with an anesthesiologist, they are much more cost effective than AAs. With an AA, the need exists to educate and use two providers – the

supervising anesthesiologist and the AA – to provide anesthesia care to one patient. With a CRNA, only that individual is needed to provide total anesthesia care to the patient. Essentially, compared with the anesthesiologist-AA staffing arrangement, one CRNA can provide the care of two providers.

AAs are an unproven provider. No peer-reviewed studies in scientific journals have been published regarding the quality of care of AA practice or AA anesthesia outcomes. The quality of care that AAs provide is unproven, as there is no meaningful research data concerning AA anesthesia safety. In contrast, the excellent, safe anesthesia care that CRNAs provide and associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.

It makes no sense to authorize AAs, a less qualified anesthesia provider that can only work with anesthesiologists and can't be used in any area where anesthesiologists don't practice, such as many rural locations. Please reject the application for licensure of anesthesiologist assistants.

Sincerely,

Dr. Julie Anne Chinnock, ND, MPH, CRNA
503-806-0426

Dear Ms. Thomas:

As a certified registered nurse anesthetist (CRNA) at Harborview Medical Center and a member of the Washington Association of Nurse Anesthetists (WANA), I am incredibly disappointed that the Department of Health recommends anesthesiologists assistant licensure in its draft sunrise report. The public will not be protected by licensing anesthesiologist assistants (AAs). I urge you to change your recommendation and reject the licensure of AAs.

The administration of anesthesia, including general anesthesia, has inherent risks to patients. These risks include pain, nausea and vomiting, laryngeal damage, anaphylaxis to anesthetic agents, cardiovascular collapse, respiratory depression, and dizziness. We must ensure that all anesthesia providers are safe to practice and are equipped with the skills to respond to medical emergencies. The administration of anesthesia is safe because of the skillset and training of the provider, their ability to immediately intervene to maintain patient stability, and continuously evaluate the interventions to maintain patient safety. A "simple anesthetic" does not exist.

AA education and training do not ensure the critical thinking skills necessary to respond to immediate patient emergencies. **For example, there is no requirement for AAs to have any patient care experience before beginning their training. AAs do not have a broad foundation to reference when a patient's condition deteriorates.** When life and death decisions are required, the operating surgeon will be forced to step in until the anesthesiologist, who is caring for other patients under anesthesia throughout a hospital, becomes available. This situation places the patient at immense risk at their most vulnerable of moments. Results will negatively impact the patient, provider, surgeon, and hospital.

Citizens of Washington State deserve proven, safe providers. **AAs' quality of care remains unknown; no meaningful research data exists concerning AA anesthesia quality and safety.** The anesthesia care team model, whose supervision is mandated, is inefficient, costly, and concerning their lack of experience, would leave patients vulnerable. In contrast, the excellent, safe anesthesia care that CRNAs offer with associated anesthesia outcomes has been repeatedly demonstrated in peer-reviewed studies published in prominent journals.

Washington state must support its existing, high-quality anesthesia providers, CRNAs, and physician anesthesiologists. Licensure for a narrowly trained provider with limited usefulness will not be beneficial in many healthcare settings, especially during our current COVID crisis. **CRNAs are prepared to be instrumental in providing access to quality care while decreasing healthcare costs (please see the image attached at the end of this letter). As previously mentioned, there is no data supporting the safety and quality of AAs.**

The effort to introduce AAs in Washington state should be rejected because there is no supporting data supporting their safety and quality. Furthermore, they are dependent on working under physician anesthesiologists, which increases costs for both the hospital and the consumer.

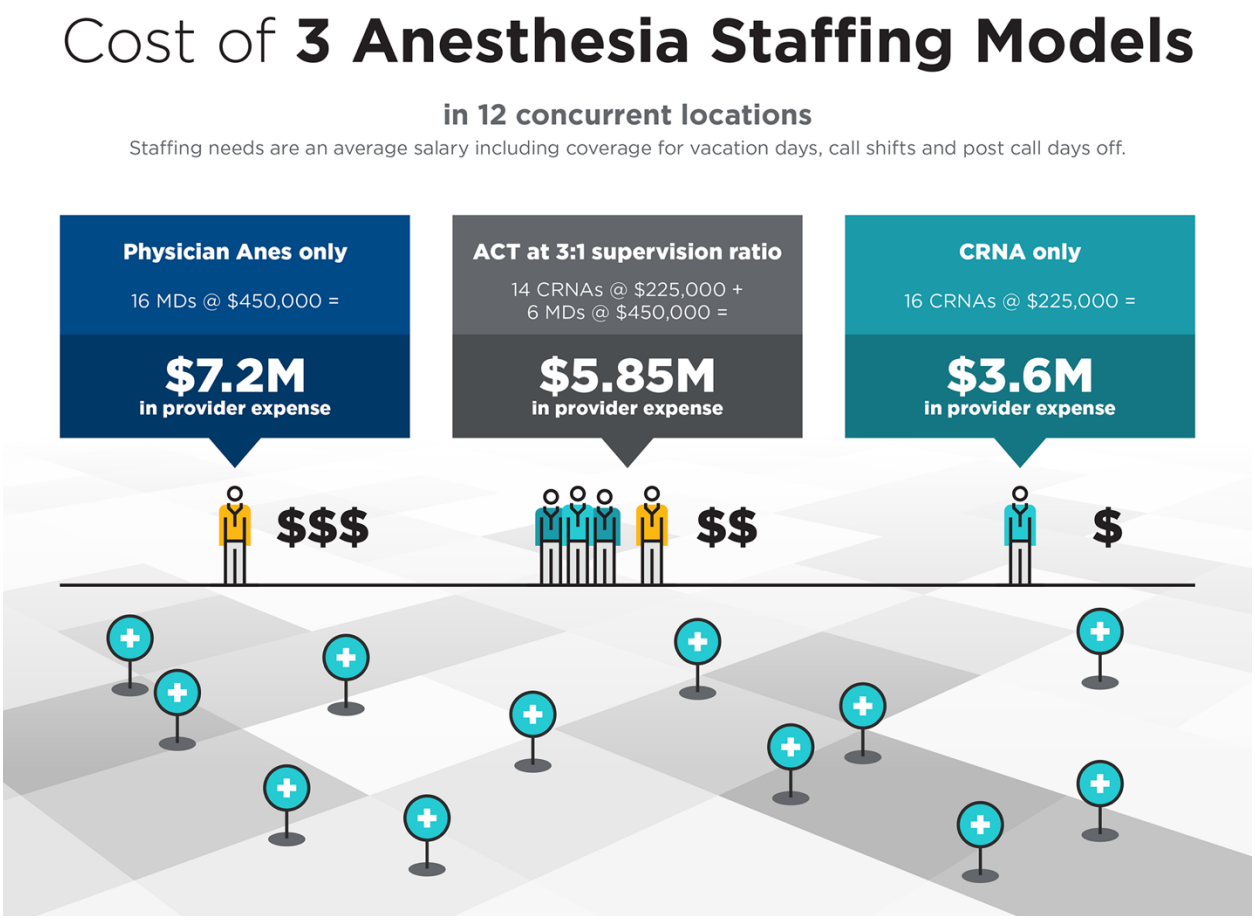
For over 150 years, CRNAs have been safely providing anesthesia in a variety of settings. Whether functioning independently or in teams with physician anesthesiologists, the

evidence and economics of nurse anesthetists is undisputed and supported by the research evidence.

CRNAs were once referred to as the "best-kept secret in healthcare." We must stand by the value we have brought to the field of anesthesia and the quality of care and safety we continue to provide for our patients. CRNAs have been and will continue to be the answer to providing access to anesthesia care in a cost-efficient manner without compromising quality and safety.

Please reject licensure for anesthesiologist assistants.

Sincerely,
Adrianna Silva
Harborview Medical Center, Department of Anesthesiology
phone: (206) 353-3566
e-mail: adrianna.lauren.silva@gmail.com



Dear Ms. Thomas,

As certified registered nurse anesthetist (CRNA) actively practicing in Washington State and a member of the Washington Associationof Nurse Anesthetists (WANA), I urge you to reject the sunrise review application regarding licensure for anesthesiologist assistants (AAs). AAs do not improve access to care in Washington; in fact, there is reason to believe they will result in restricting access and driving up costs. AAs are narrowly trained and cannot practice without a licensed anesthesiologist.
Finally, AAs are an unproven provider with no peer-reviewed studies that prove the safety of AAs.

Certified Registered Nurse Anesthetists (CRNAs) are certified anesthesia experts independently licensed to practice in all 50 states and the District of Columbia. Because of their extensive education and training, CRNAs are permitted by federal and state laws and regulations to provide every type of anesthesia service to patients without the involvement or presence of a physician anesthesiologist. All research studies on anesthesia safety and cost-effectiveness conducted in the last 20 years confirm that CRNAs provide the safest, most cost-effective anesthesia care to patients.

In contrast, AAs can only practice in 15 states plus the District of Columbia. They are limited by their training and licensure to providing clinical support to anesthesiologists and may not practice "apart from the supervision of an anesthesiologist," according to the American Academy of Anesthesiologist Assistants (AAAA). Because AAs are required to be directly supervised by an anesthesiologist, the AA/anesthesiologist team is one of the costliest anesthesia delivery models with no scientific evidence of increased patient safety.

Because AAs cannot practice without anesthesiologist supervision, AAs do not practice in rural areas where CRNAs working without anesthesiologist involvement are the primary providers of anesthesia care. In fact, CRNAs are the only anesthesia provider in 72% of Washington's rural hospitals. AAs, in contrast, can only practice where anesthesiologists practice, which greatly limits their utilization. AAs, therefore, can't help solve problems of inadequate access to anesthesia care in rural and underserved communities.

If for any reason an AA's supervising anesthesiologist is not available, off-site, on vacation, or simply home for the day, the AA may not provide anesthesia care. The AA anesthesiologist-driven mode of practice, therefore, is inflexible and fails to adequately meet the needs of patients, hospitals, ambulatory surgical centers, or other healthcare settings.
While nurse anesthesia educational programs graduate nurse anesthetists prepared for autonomous practice, the AA program curriculum is characterized by training that only allows them to assist anesthesiologists in technical functions.

Because CRNAs do not need to practice with an anesthesiologist, they are much more cost effective than AAs. With an AA, the need exists to educate and use two providers – the

supervising anesthesiologist and the AA – to provide anesthesia care to one patient. With a CRNA, only that individual is needed to provide total anesthesia care to the patient. Essentially, compared with the anesthesiologist-AA staffing arrangement, one CRNA can provide the care of two providers.

AAs are an unproven provider. No peer-reviewed studies in scientific journals have been published regarding the quality of care of AA practice or AA anesthesia outcomes. The quality of care that AAs provide is unproven, as there is no meaningful research data concerning AA anesthesia safety. In contrast, the excellent, safe anesthesia care that CRNAs provide and associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.

It makes no sense to authorize AAs, a less qualified anesthesia provider that can only work with anesthesiologists and can't be used in any area where anesthesiologists don't practice, such as many rural locations. Please reject the application for licensure of anesthesiologist assistants.

Sincerely,

Darryl DuVall, DNP, CRNA, ARNP

Dear Ms. Thomas:

As a certified registered nurse anesthetist (CRNA) and a member of the Washington Association of Nurse Anesthetists (WANA), I am extremely disappointed that the Department of Health is recommending anesthesiologist assistant licensure in its draft sunrise report. The public will not be protected by licensing anesthesiologist assistants (AAs). I urge you to change your recommendation and reject licensure of AAs.

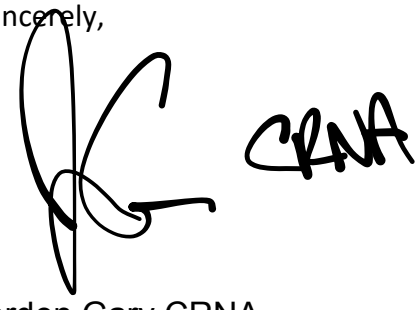
The administration of anesthesia, including general anesthesia, has inherent risks to patients. These risks include pain, nausea and vomiting, laryngeal damage, anaphylaxis to anesthetic agents, cardiovascular collapse, respiratory depression, and dizziness. We must ensure that all anesthesia providers are safe to practice and are equipped with the skills to respond to medical emergencies. The administration of anesthesia is safe because of the skillset and training of the provider, their ability to immediately intervene to maintain patient stability, and continuously evaluate the interventions to maintain patient safety. A "simple anesthetic" does not exist.

AA education and training does not ensure the critical thinking skills necessary to respond to immediate patient emergencies. For example, there is no requirement for AAs to have any patient care experience prior to beginning their training. AAs do not have a broad foundation to reference when a patient's condition deteriorates. When life and death decisions are required, the operating surgeon will be forced to step in until the anesthesiologist, who is caring for other patients under anesthesia throughout a hospital, becomes available. This situation places the patient at immense risk at their most vulnerable of moments. Results will negatively impact the patient, provider, surgeon, and hospital.

Citizens of Washington State deserve proven, safe providers. The quality of care that AAs provide remains unknown; no meaningful research data exists concerning AA anesthesia quality and safety. The anesthesia care team model, which their supervision is mandated, is inefficient, costly, and concerning their lack of experience, would leave patients vulnerable. In contrast, the excellent, safe anesthesia care that CRNAs offer with associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.

Washington state must support its existing, high quality anesthesia providers, CRNAs and physician anesthesiologists. Licensure for a narrowly trained provider with limited usefulness will not be beneficial in many healthcare settings, especially during our current COVID crisis. CRNAs are prepared to be instrumental in providing access to quality care while decreasing healthcare costs. Please reject licensure for anesthesiologist assistants.

Sincerely,



Jorden Gary CRNA