Dear Dr. Singh:

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to submit comments to the Department of Health and Human Service Pain Management Best Practices Inter-Agency Task Force’s Draft Report on Pain Management Best Practices: Updates, Gaps, Inconsistencies and Recommendations. For further information on the AANA, whose membership includes more than 53,000 certified registered nurse anesthetists (CRNAs) and student registered nurse anesthetists (SRNAs), who provide safe, effective and high-quality anesthesia and pain management services, please see our previous letters to the task force sent on May 24, 2018 and September 14, 2018.1


We are pleased that there is representation of APRNs on the task force, however, we feel this report does not properly recognize the full panoply of qualified providers, including CRNAs, who deliver pain management services across the country. The emphasis of the report is on physicians who provide pain management and overlooks the critical role of other provider types in delivering these vital services. This could adversely impact the chronic pain workforce, severely limiting access to these services. This report also disregards the HHS’ December 2018 report “Reforming America’s Healthcare System through Choice and Competition” which stated that APRNs can safely and effectively provide some of the same healthcare services as physicians and that “government rules restrict competition if they keep healthcare providers from practicing to the top of their license— i.e., to the full extent of their abilities, given their education, training, skills, and experience, consistent with the relevant standards of care.”2 As a main provider of pain management services, CRNAs are qualified pain practitioners who have the training and experience to provide access to excellent care in many practice settings to treat patients suffering from a wide range of acute and chronic pain conditions. The AANA believes that patients are best served when healthcare professionals practice to their full scope of practice, education and licensure, without barriers, collaboratively on a team that promotes safe, high-quality, value-driven, patient centered care.3 This type of care is not a value held by one profession or the responsibility of one healthcare professional, but rather is the culture of care embraced by the interdisciplinary, patient-driven team. The AANA strongly encourages interdisciplinary collaboration among the patient’s team utilizing effective communication and leveraging the unique roles and responsibilities of all interdisciplinary team members.4,5,6,7,8 Therefore, we advise that CRNAs should not face professional discrimination based solely on licensure in these efforts and that the task force work to ensure that all pain providers are recognized in this report.

II. 2.1 Acute Pain (Gap 1, Recommendation 1b)

The AANA supports the use of multidisciplinary regarding the use of multimodal approaches for perioperative pain control such as anesthesia Enhanced Recovery After Surgery (ERAS) protocols. As a main provider of pain management services, CRNAs play an integral role in these episodes of care as proper anesthesia services management can make a tremendous difference in terms of improving patient flow, patient safety, and cost savings.9 This is shown in a recent study which calls for an increased number of nursing pain

specialists “to not only implement aggressive acute pain care to prevent chronic pain but also to effectively treat chronic pain with evidence-based integrative therapies that include multimodal analgesia, interventional techniques, and complementary and alternative approaches to pain management.”

For further information on CRNA use of ERAS, please see the AANA’s letters to the task force from May 24 and September 14, 2018.

III. 2.2 Medication (Gap 3, Recommendation 3a)
The AANA supports the task force’s recommendations that use of nonopioid medications should be used as first line therapy to treat pain and that all pain management providers should understand the use of non-opioid medication for managing different components of pain syndromes. Use of non-opioid alternatives, such as multi-modal pain management services do lead to a decrease in prescription opioid use and addiction and this especially holds true considering the increasing opioid crisis across the country. For further information on the holistic, multimodal approach that CRNAs employ when treating their chronic pain patients which may reduce the reliance on opioids as a primary pain management modality, thus mitigating the risk of dependency, please see the AANA’s letters to the task force from May 24 and September 14, 2018.

IV. 2.4 Interventional Procedures (Gap 3, Recommendations 3a- 3c)
While we appreciate that Recommendation 1c under Section 3.3.3 calls for expansion of the availability of nonphysician pain specialists, however, we are concerned with the report’s recommendations for credentialing and training requirements are not based on evidence and wind up limiting the pathways available for non-physician practitioners, such as CRNAs, to be able to provide interventional pain procedures.

We request these recommendations be amended to include CRNAs education and training as an adequate path to competence and request that the credentialing and training requirements be amended to be inclusive of CRNAs and all types of qualified practitioners and their educational pathways. We also request that the report also recognize CRNAs who specialize in pain management and recognize nurse anesthesia programs accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs (COA) and certification and recertification by the National Board for Certification and Recertification of Nurse Anesthetists (NBCRNA).

Regarding CRNA education and preparation, CRNAs have a minimum of 7 to 8 ½ calendar years of education and experience specific to nursing and anesthesia before they are licensed to practice anesthesia. The minimum education and experience required to become a CRNA include: a) a baccalaureate or graduate degree in nursing; b) an unencumbered license as a registered professional nurse and/or an advanced practice registered nurse (APRN) in the United States; c) a minimum of one year full-time working experience as a registered nurse in a critical care setting, of which the average experience of RNs entering nurse anesthesia education programs is 2.9 years; d) graduation with a minimum of a master’s degree from a nurse anesthesia educational program accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs (COA); and e) passage of the National Certification Examination (NCE).

As part of their educational preparation, CRNAs are required to learn and demonstrate competence in the management of pain, a critical component in the delivery of anesthesia care. All CRNAs are certified and recertified to practice by the NBCRNA, an accredited nationally recognized organization. By virtue of education and individual clinical experience, a CRNA possesses the necessary knowledge and skills to employ therapeutic, physiological, pharmacological, interventional, and psychological modalities in the management and treatment of acute and chronic pain. Nurse anesthesia education, experience, and skill development to practice pain management are core elements of nurse anesthesia education programs. The standards issued by the COA mandate that nurse anesthesia programs provide content in, but not limited to, anatomy, physiology, pathophysiology, pharmacology, and acute and chronic pain management, and the standards require that SRNAs obtain clinical experiences in regional anesthetic techniques (i.e., spinal, epidural, and peripheral nerve blocks). See again Exhibit 1 for COA Standards and see Exhibit 2 for the NCE Handbook.

As professionals, CRNAs engage in life-long learning and quality improvement activities for safety and excellence in all aspects of patient-centered anesthesia care, including procedures for chronic pain management practice. CRNAs who provide pain management do so in accordance with their professional scope of practice, federal and state law, and facility policy. As providers integrate new technologies and techniques into their practices, they acquire and demonstrate the necessary knowledge, skills, and abilities. Fellowship training, although not required for either CRNAs or anesthesiologists, is available to those who would like further recognition in the field of pain management. It is incumbent upon each individual health care professional to assure his or her competency when providing patient care, including pain management and treatment. See Exhibit 3 for AANA’s CRNA Specialty Clinical Practice Position Statement.

See Exhibit 4 for the COA Standards for Accreditation of Post-Graduate CRNA Fellowships. See Exhibit 5 for the letter from NBCRNA’s Chief Executive Officer describing the voluntary Nonsurgical Pain Management subspecialty credential (NSPM-C) for nurse anesthetists offered by the NBCRNA, which also includes a) an outline of the NSPM examination criteria published in the NBCRNA’s NSPM-C Handbook, b) an example of how CRNAs can fulfill the educational requirement for the NSPM-C credential (Advanced Pain Management Fellowship from Texas Christian University [TCU]), and c) the Pain Medicine Examination Blueprint published by the

American Board of Anesthesiology, Inc. (ABA), which is included to show that the content of the NSPM exam is substantially equivalent to that of the ABA.

The AANA’s long-held position is that it is within a CRNA’s scope of practice to provide “acute, chronic and interventional pain management services...” and CRNA scope of practice includes “the use of ultrasound, fluoroscopy, and other technologies for diagnosis and care delivery, and to improve patient safety and comfort.”11 In addition, “[b]y virtue of education and individual clinical experience and competency, a CRNA may practice chronic pain management utilizing a variety of therapeutic, physiological, pharmacological, interventional, and psychological modalities in the management and treatment of pain.”12 Interventional pain management is not exclusively the practice of medicine. When performed by a nurse anesthetist, interventional pain management is the practice of nursing. State legislatures, through licensing laws, determine what is and is not the practice of medicine and what is and is not in the public’s best interest. Licensing laws, however, do not create monopolies for professions. Many professions are authorized to practice in the same, related, or similar fields and as a result have overlapping practice areas. Because of this overlap, many areas of practice are not the exclusive province of one healthcare profession or solely the practice of “medicine.”

Furthermore, the Medicare agency in its 2013 final rule covering all Medicare services provided by CRNAs within their state scope of practice.13 Medicare regulations state: “Medicare Part B pays for anesthesia and related care furnished by a certified registered nurse anesthetist or an anesthesiologist’s assistant who is legally authorized to perform the services by the State in which the services are furnished.”14 “Anesthesia and related care” are defined as “those services that a certified registered nurse anesthetist is legally authorized to perform in the state in which the services are furnished.”15 In the preamble to the CY 2013 Medicare Physician Fee Schedule Final Rule, the Centers for Medicare & Medicaid Services (CMS) said that it would defer to a state regarding what services are within a CRNA’s scope of practice.16 CMS does not defer to any particular medical society’s guidelines, nor are any such medical society’s guidelines mentioned in the preamble language. CMS concluded, “Anesthesia and related care means those services that a certified registered nurse anesthetist is legally authorized to provide in the state in which the services are furnished.”17 CMS has instituted this policy at Section 140.4.3 – Payment for Medical or Surgical Services Furnished by CRNAs.18 The policy states “Payment is determined under the physician fee schedule on the basis of the national physician fee schedule conversion factor, the geographic adjustment factor, and the resource-based relative value units for the medical or surgical service.” Nowhere in this policy does it state that CRNAs must be medically directed.

Regarding the credentialing requirements contained in Recommendation 3a and 3b, the AANA requests background information to understand the requirements that credentialing criteria must be established to participate in pain management and that only clinicians who are credentialed in pain procedures can perform interventional procedures. Absent compelling evidence supporting the recommendation for its patient safety benefits, and we are not aware of the existence of such evidence, and we recommend this proposed requirement be stricken from the report.

The AANA appreciates this opportunity to comment. Should you have any questions, please feel free to contact the AANA Senior Director of Federal Government Affairs, Ralph Kohl, at 202-741-9080 or rkohl@aanadc.com.

Sincerely,

Garry Brydges, DNP, MBA, ACNP-BC, CRNA
AANA President