January 13, 2016

National Center for Injury Prevention and Control
Centers of Disease Control and Prevention
4770 Buford Highway NE
Mailstop F-63
Atlanta, GA 30341

Attn: Docket CDC-2015-0112


To Whom It May Concern:

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to provide written comments on the draft Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain (80 Fed. Reg. 77351, Dec. 14, 2015. The AANA makes the following comments and requests:

- Harmonize Specialty and Care Setting Guidelines for Prescribing Opioids to Minimize Variation in Care Across the Patient’s Healthcare Experience.

- Include in the Seventh Recommendation that the Primary Care Provider Should Work with a Chronic Pain Specialist after Three Months of Initiating Opioid Therapy.

**Background of the AANA and CRNAs**

The AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student nurse anesthetists, and AANA membership includes more than 49,000 CRNAs and student nurse anesthetists representing over 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who personally administer more than 40 million anesthetics to patients each year in the United States. Nurse anesthetists have provided anesthesia in the United States for 150 years, and high-quality, cost-effective CRNA services continue to be in high demand. CRNAs are Medicare Part B providers and since 1989, have billed Medicare directly for 100 percent of the physician fee schedule amount for services.
CRNA services include providing a pre-anesthesia patient assessment, obtaining informed consent for anesthesia administration, developing a plan for anesthesia administration, administering the anesthetic, monitoring and interpreting the patient's vital signs, and managing the patient throughout the surgery. CRNAs also provide acute and chronic pain management services. CRNAs provide anesthesia for a wide variety of surgical cases and in some states are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities. According to a May/June 2010 study published in the journal of Nursing Economic$, CRNAs acting as the sole anesthesia provider are the most cost-effective model for anesthesia delivery, and there is no measurable difference in the quality of care between CRNAs and other anesthesia providers or by anesthesia delivery model.\(^1\) Furthermore, an August 2010 study published in Health Affairs shows no differences in patient outcomes when anesthesia services are provided by CRNAs, physicians, or CRNAs supervised by physicians.\(^2\)

Researchers studying anesthesia safety found no differences in care between nurse anesthetists and physician anesthesiologists based on an exhaustive analysis of research literature published in the United States and around the world, according to a scientific literature review prepared by the Cochrane Collaboration.\(^3\)

According to a 2007 Government Accountability Office (GAO) study, CRNAs are the principal anesthesia provider where there are more Medicare beneficiaries and where the gap between Medicare and private pay is less.\(^4\) Nurse anesthesia predominates in Veterans Hospitals and in the U.S. Armed Forces. CRNAs work in every setting in which anesthesia is delivered including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers (ASCs), pain management facilities, and the offices of dentists, podiatrists, and all types of specialty surgeons.

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AANA Request: Harmonize Specialty and Care Setting Guidelines for Prescribing Opioids to Minimize Variation in Care Across the Patient’s Healthcare Experience

While we agree with the CDC that it is reasonable to focus the guideline on primary care providers, the AANA believes the guideline should be inclusive of all prescribers across settings to optimize the impact on safe and appropriate use of opioids for chronic pain. As there is no bright line between acute and chronic pain, opioid use disorder may originate or become evident in many care settings. We therefore recommend that the CDC harmonize the guidelines across care settings and specialties. We appreciate that this will require an even larger global education program. We believe that being prescriber-inclusive will minimize variation in care across the patient’s healthcare experience.

The AANA stands ready to work with the agency to support the integration of this guideline into practice. Please consider the valuable contribution that APRNs and specifically CRNAs will offer the interprofessional teams who create the policy and resources necessary to make this guideline the standard for pain management. As APRNs, CRNAs are uniquely skilled to deliver pain treatment in a compassionate and holistic manner. By 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. The comprehensive holistic nursing perspective of the patient focuses on multimodal management of pain to limit or eliminate the use of opioids, and on collaborative team management of the patient to optimize non-pharmacological therapies. This type of knowledge and practice experience would prove invaluable as the agency works to integrate this guideline into practice.

AANA Request: Include in the Seventh Recommendation that the Primary Care Provider Should Work with a Chronic Pain Specialist after Three Months of Initiating Opioid Therapy

The seventh recommendation states “the provider should evaluate the benefits and harms of continued therapy with patients every three months or more frequently.” The primary care provider should take no more than three months in managing the patient on his or her own. At that point, we recommend

that the primary care provider should consult with specialty care to design a comprehensive treatment plan to address the patient’s pain and optimize quality of life. While the corresponding text does suggest that a primary care provider consult a pain specialist, this point is buried and could be easily missed by the provider who is responsible for developing a treatment plan. We therefore recommend that the seventh recommendation specifically state that the primary care provider seek specialty care within three months of initiating opioid therapy. This recommendation will help ensure that the patient is receiving safe and effective care.

We thank you for the opportunity to comment on this draft guideline. Should you have any questions regarding these matters, please feel free to contact the AANA Senior Director of Federal Government Affairs, Frank Purcell, at 202.484.8400, fpurcell@aanadc.com.

Sincerely,

Juan F. Quintana, CRNA, MHS, DNP
AANA President

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