Chronic Pain Management Guidelines

Purpose

The purpose of these guidelines is to support Certified Registered Nurse Anesthetists (CRNAs) in the delivery of safe and effective chronic pain management and treatment. An interdisciplinary team approach that uses a multidimensional pain strategy and integrates the patient’s unique experiences and perspective may help achieve effective pain management and treatment with the goal to improve the patient’s well-being, functionality, and quality of life. The guidelines emphasize the importance of reduction in the risk of opioid overdose and need for prescription opioids, which may lead to opioid use disorder.1

The Chronic Pain Management Guidelines are intended to promote high-quality care and do not assure specific outcomes. The Standards for Nurse Anesthesia Practice2 are the foundation for chronic pain management practice. The Scope of Nurse Anesthesia Practice3 affirms that chronic and interventional pain management services are within the CRNA scope of practice.

Background

Definition of Pain

The International Association for the Study of Pain (IASP) recently revised its definition of pain to “an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage.”4 The new definition includes six key notes that provide further context for understanding pain as a multidimensional, complex experience:4

- “Pain is always a personal experience that is influenced to varying degrees by biological, psychological, and social factors.”
- “Pain and nociception are different phenomena. Pain cannot be inferred solely from activity in sensory neurons.”
- “Through their life experiences, individuals learn the concept of pain.”
- “A person’s report of an experience as pain should be respected.”
- “Although pain usually serves an adaptive role, it may have adverse effects on function and social and psychological well-being.”
- “Verbal description is only one of several behaviors to express pain; inability to communicate does not negate the possibility that a human or a nonhuman animal experiences pain.”

Types of Pain

Pain exists along a continuum. Acute pain typically occurs suddenly and has a specific cause, such as tissue injury that lasts less than three months.5,6 If left untreated, acute pain may lead to chronic pain making the patient more sensitive to pain (hyperalgesia) and experience severe pain even from nonpainful stimuli (allogynia).7,8
Chronic non-cancer pain is defined as ongoing or recurrent pain that is moderate or severe, lasting more than three months. It includes conditions such as low back pain, osteoarthritis, rheumatoid arthritis, neuropathic pain, and fibromyalgia.5,6

Epidemiology

In 2016, chronic pain affected an estimated 20.4 percent of U.S. adults, approximately eight percent of which had high-impact chronic pain that interfered with their ability to work outside the home.9

Chronic pain represents a significant economic burden, costing between $560 billion to $635 billion annually in healthcare expenses and lost productivity.10 It remains the top reason people seek healthcare.11

People with chronic pain are at high risk for opioid misuse and addiction. For example, a systematic review of 38 studies reports opioid misuse rates of 21 to 29 percent and addiction rates of eight to twelve percent in patients with chronic pain.1

Untreated chronic pain can negatively affect individuals, and contribute to limited function, depression, anxiety, and reduced quality of life.9 For example, patients who are diagnosed with both depression and chronic pain tend to experience worse outcomes compared to patients diagnosed with chronic pain only. Patients with dual diagnosis should be closely monitored to avoid progression to severe pain.12

Research suggests there is a link between chronic pain and posttraumatic stress disorder (PTSD).13 For example, two systematic reviews by Siqveland et al. (N=21) and Fishbain et al. (N=40) reported mean PTSD prevalence rates of 11.7 to 19.1 percent in clinical pain populations (the authors noted sizable subgroup differences that warrant further research).14,15 It is also estimated that patients with a primary PTSD diagnosis have prevalence of chronic pain as high as 80 percent.16,17 This issue is important and deserves healthcare professionals’ attention, as individuals with both chronic pain and PTSD are more likely to experience greater pain, PTSD symptoms, depression, anxiety, disability, and opioid use compared to those with only one of these conditions.18

Chronic pain can contribute to suicide risk. In a recent study, Petrosky et al.19 examined 123,181 suicide deaths across 18 states between 2003 and 2014. They found that almost nine percent of cases had evidence of chronic pain, with back pain, cancer, and arthritis being the leading causes of suicide in this chronic pain subpopulation. Certain groups such as veterans and individuals with fibromyalgia are at increased risk of suicide, especially if they have both chronic pain and mental health diagnoses.20,21 Additionally, individuals who experience both chronic pain and PTSD are at risk of suicidal behavior.18

Risk Factors

The experience of chronic pain is unique to each patient and involves complex biological (e.g., age, gender), psychological (e.g., childhood trauma), and social (e.g., social and economic disadvantages) factors.22 As people age, they are at high risk for developing chronic pain conditions, such as osteoarthritis, diabetic neuropathy, and post-stroke pain.23,24 Women are
more likely than men to report chronic pain; they are also more likely to experience a higher level of pain intensity and higher pain-related disability than men.

Social and economic disadvantages correlate with chronic pain. Low socioeconomic status, being a racial/ethnic minority, poverty, unemployment, geographic isolation, and inadequate insurance coverage are associated with higher prevalence and intensity of chronic pain compared to people without these characteristics.

Other important predictors of chronic pain include the presence of another site of acute or chronic pain within the body, obesity, sleep disorders, and past surgeries and medical interventions. Lifestyle factors may also play a role in contributing to chronic pain and include smoking and alcohol use, low levels of physical activity, living in colder climates, and low levels of vitamin D. Those who experienced stressful events in childhood, such as neglect or abuse, are at an increased risk of chronic stress in adulthood.

Mental health conditions, such as anxiety and depression, and negative emotions, such as anger, can exacerbate chronic pain and reduce quality of life. Self-efficacy (i.e., one’s belief that they can exercise control over pain), pain acceptance, and access to a social support network may act as protective factors.

CRNA Scope of Practice

CRNAs practice in accordance with their professional scope of practice, federal, state, and local law, facility accreditation standards, and healthcare organization policy to provide chronic pain management services.

As advanced practice registered nurses, CRNAs are uniquely skilled to deliver pain management in a compassionate and holistic manner. CRNAs provide chronic pain management services in various settings, such as hospitals, ambulatory surgical centers (ASCs), offices, and pain management clinics. 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.

As part of their nurse anesthesiologist educational preparation, CRNAs learn and demonstrate competence in the management and treatment of pain, a critical component of anesthesia care. The Council on Accreditation of Nurse Anesthesia Educational Programs (COA) standards require that nurse anesthesia programs provide content in anatomy, physiology, pathophysiology, pharmacology, and pain management, and require that nurse anesthesia students obtain clinical experiences in regional anesthetic techniques (i.e., spinal, epidural, and peripheral nerve blocks).

As knowledge of the pain experience, corresponding neurobiology, pain management and treatment modalities, and related technologies evolve, the role of healthcare professionals in managing and treating pain will also evolve. These advancements will translate into clinical practice with the goal of improving patient outcomes. For additional guidance, review the AANA’s CRNA Specialty Clinical Practice.
An Interdisciplinary Team Approach

CRNAs provide chronic pain management services in a variety of practice models based on patient, provider, and facility needs. CRNAs may work with a primary care provider, orthopedist, neurologist, psychiatrist, social worker, radiologist, physical therapist, another pain specialist, or other providers. The CRNA may receive referrals from other clinicians or serve as the sole provider of chronic pain management services. CRNAs provide patient-centered chronic pain management and treatment, working toward the common goal of decreasing the patient’s pain and improving the patient’s quality of life and functionality.

When working in collaboration with a patient’s primary care provider or other referring clinician, CRNAs may share certain responsibilities of chronic pain management. The CRNA reviews and may add relevant findings (e.g., history and physical, diagnostic results) to information provided by a referring clinician to administer chronic pain management services safely. CRNAs are responsible and accountable for judgments made and actions taken in their professional practice.

Chronic Pain Management Guidelines

1. Patient Assessment and Evaluation
The goal of patient assessment and evaluation is to understand the nature, causes, and severity of pain, and their impact on the patient’s functionality, mood, and overall quality of life. This information will help establish a diagnosis and formulate an appropriate plan of care with specific objectives of treatment.

Pain is a subjective experience. The patient’s ability to communicate their pain may depend on personal attributes (e.g., age, developmental stage, culture), as well as physiological, emotional, and cognitive states. The patient may feel reluctant to discuss their pain openly with a healthcare professional for fear of being judged (e.g., being perceived as responsible for their own pain or come across as complaining too much).

Establishing a patient-CRNA relationship based on communication, empathy, openness, trust, and a non-judgmental attitude is the first step to understanding the patient’s perception of and experience with pain. The following questions may serve as a guide in the initial patient-CRNA discussion:

- **Onset:** Tell me about your pain: When did it start? How long does it last? How often does it occur?
- **Location:** Where do you feel pain? Do you feel pain in more than one area?
- **Severity:** On a 0-10 scale, where 0 is no pain and 10 is the worst pain imaginable, what is your pain now? … in the last 24 hours? [Note: There are other available tools to help assess pain, such as Brief Pain Inventory or Wong-Baker FACES® Pain Rating Scale.]
- **Quality:** What does your pain feel like (e.g., aching; dull; sharp; burning; unbearable)?
- **Alleviating/aggravating factors:** What makes your pain better/worse? How does it affect you (e.g., sleep, mood, relationships)? Are there any other symptoms?
• **Expectations:** *Do you expect your pain to improve?*

In addition to the initial discussion, the CRNA should perform a comprehensive patient assessment and evaluation. The patient health history should involve a review of the following: (a) the patient’s medications, including use or misuse; (b) allergies; (c) health and surgical history; (d) psychosocial health, including substance use or misuse; and (e) issues related to respiratory, cardiovascular, renal, hepatic, gastrointestinal, neurologic, endocrine, musculoskeletal, and hematologic systems.²,₄₀

The CRNA should conduct a focused pain assessment and evaluation addressing pain symptoms, identification of pain risk factors, and current and previous pain management, including physical and cognitive therapies, alternative modalities, and responses to these therapies.⁴¹ Validated instruments should be used when appropriate to evaluate the patient’s quality of life, physical, social, emotional functions, and sleep quality.⁴¹-⁴⁴ For examples of validated instruments, see the American Academy of Family Physician’s Chronic Pain Toolkit.⁴⁵ The CRNA should also review the patient’s diagnosis and results of relevant diagnostic testing and psychological evaluation.

The CRNA may perform further non-interventional and interventional diagnostic procedures in the assessment and evaluation of the patient’s pain that can be used to establish the diagnosis. These procedures may include, but are not limited to, laboratory testing, diagnostic imaging, electrodiagnostic studies, and focused regional injections as indicated.⁴¹,⁴⁶,⁴⁷

2. **Management**
   a. **Plan of Care**
      The CRNA should formulate a patient-specific management and treatment plan based on findings from the comprehensive assessment and evaluation. The plan should also consider the patient’s values, beliefs, and knowledge and level of understanding about pain, pain management and treatment options.⁴⁸,⁴⁹

      The plan should integrate baseline functional capacity and set realistic functional goals, including measurable targets for pain management.⁵⁰ A plan to implement alternative modalities should be considered and developed, as appropriate, if the original goals and targets are not met.

   b. **Communication**
      The CRNA and the patient’s treatment team and primary care provider or referring clinician should have ongoing communication regarding the patient’s status, treatment plan, treatment compliance, and prognosis to coordinate the plan for ongoing chronic pain management.⁴⁸,⁵¹,⁵²

   c. **Patient Education**
      Patient and family/caregiver education should be made available in their preferred method and language regarding etiology of pain, management/treatment plan and
goals, potential alternative therapy, and consequences for non-adherence to the plan.\textsuperscript{51,53-55} Evidence suggests patients who understand their chronic condition are more effective at managing it and report better outcomes compared to those without such knowledge.\textsuperscript{56}

The CRNA should discuss possible side effects and complications of the regimen with the patient and family/caregiver. In addition, the CRNA should provide instructions to address side effects and respond to complications, should they occur.\textsuperscript{57}

Managing the patient’s expectations is critical for successful pain management and treatment. The CRNA and the patient should agree on realistic goals of pain management and how to achieve them (see the “Plan of Care” section above).

While patients may experience significant improvement in chronic pain with treatment, complete elimination of pain may not be possible. According to recent estimates, on average, patients achieve only 30 percent reduction in pain with treatment. The CRNA should communicate to the patient that even an incremental reduction in pain can have a positive impact on function and overall quality of life.\textsuperscript{56} Failure to manage patients’ expectations early in the process may lead to non-adherence to the plan, poor satisfaction with services received, and poor health outcomes.\textsuperscript{58}

When working with racial/ethnic minorities and socioeconomically disadvantaged patients, the CRNA should be aware that these populations are at increased risk for all-cause morbidity and mortality; they may also face psychosocial issues that make them especially vulnerable to undertreatment for pain. By understanding the patient’s perspective, the CRNA can provide effective education that is compassionate and empathetic, thereby reducing stigma, biases, and discrimination.\textsuperscript{37,59} For additional guidance, review the AANA’s \textit{CRNA’s Role in Addressing Racial and Ethnic Disparities in Anesthesia Care}\textsuperscript{60}

d. Informed Consent and Treatment Agreement

The CRNA should obtain and document informed consent. The informed consent process should include a discussion of the individualized treatment plan, planned procedures, alternative methods of treatment, and risk and benefits of the plan. The patient should be able to demonstrate the “decision-making capacity” or ability to make a meaningful decision about whether or not to undergo treatment, including appreciating the significance of the plan of care and its potential consequences.\textsuperscript{57} The patient should also have an opportunity to ask questions and clarify any information. If desired by the patient, the family or caregiver may participate in this process. For additional guidance regarding informed consent, review the AANA’s \textit{Informed Consent for Anesthesia Care}.\textsuperscript{57} This document also includes recommendations on how to effectively facilitate communication with patients from diverse backgrounds and patients requiring special assistance (e.g., patients with limited English proficiency (LEP), visual or hearing impairments, learning disabilities, or cognitive impairments).
CRNAs should be aware of potential drug-seeking behavior and enter into a pain management treatment agreement with the patient, when appropriate. The pain management treatment agreement establishes an understanding of the elements of the treatment plan and outlines patient and provider responsibilities, expectations for compliance, and response to emergency issues. The pain management agreement keeps the patient more accountable and engaged in their care and increases their likelihood of adhering to the plan of care. The following questions should be addressed before the patient signs the pain management treatment agreement:

- What medications does the agreement include?
- What are the risks with the patient taking these medications?
- How does the agreement affect emergency care?
- What happens if the patient fails to follow the agreement?

If applicable, the CRNA should consult their state’s Prescription Drug Monitoring Program (PDMP), a database consisting of every patient’s controlled drug prescriptions by every provider, before prescribing a controlled substance.

e. Non-Pharmacologic Management

Results of studies of non-pharmacologic modalities have been inconclusive due to a lack of large scale, high-level research, and mixed findings regarding the effectiveness of these modalities. Overall, research suggests non-pharmacologic modalities are safe and well-tolerated, and when appropriate, should be considered as part of the plan of care. There is also evidence that limited access to non-pharmacologic services, such as physical therapy, is associated with an increase in opioid prescriptions; however, more research is needed to investigate this relationship further.

The CRNA may work with another provider to implement non-pharmacologic management modalities as part of the plan of care. These modalities may include, but are not limited to:

- Physical rehabilitation modalities: therapeutic exercise, transcutaneous elective nerve stimulation, massage therapy, traction, cold and heat therapies, therapeutic ultrasound, bracing, touch therapy.
- Psychological and behavioral health approaches: cognitive behavioral therapies, psychological skills training (PST), mindfulness-based stress reduction programs.
- Complimentary approaches: yoga, tai chi, acupuncture.

f. Pharmacologic Management

Examples of pharmacologic management modalities include, but are not limited to:

- Traditional analgesics: local anesthetics, acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDs), and opioids.
Non-traditional analgesics: anticonvulsants (e.g., gabapentin, pregabalin), N-methyl-D-Aspartate [NMDA]-receptor antagonists (e.g., ketamine), antispasmodics (e.g., baclofen, tizanidine), and antidepressants (e.g., duloxetine).

Pharmacologic treatment should be tailored to the patient’s health status (e.g., cardiovascular, hepatic, renal, and cognitive issues) due to potential for drug side effects, drug clearance, and drug-drug interactions. Pharmacologic treatment should also take into consideration the patient’s type (e.g., neuropathic vs. nociceptive) and level of pain, functionality, and response. Additionally, the patient should be assessed and treated for disturbed sleep or depressed or anxious mood that may help increase response to treatment.

Medications should be titrated incrementally to achieve an adequate level of analgesia. Tapering or discontinuing medications should be considered if the patient’s pain is not adequately controlled when taking appropriate doses or if there is no functional improvement on medication therapy.

Opioid Therapy

Non-opioid modalities should be used as the first line of treatment for chronic pain. Consider opioid therapy only if the benefits outweigh the risks and the patient is not responsive to other pharmacologic and non-pharmacologic treatment modalities. Opioids should be used at the lowest effective dose and for shortest duration of time to achieve adequate pain control, with the intention of mitigating negative side effects and opioid addiction risk.

Prior to considering/initiating opioid therapy, the CRNA should:

- Discuss the risks (e.g., addiction, overdose) and benefits of opioids, as well as alternative treatment modalities with the patient.
- After completing a comprehensive patient assessment and evaluation, assess the patient’s risk potential for overdose and substance use disorder. Risk factors include sociodemographic factors, pain and drug-related factors, genetics and environment, psychosocial and family history, psychopathology, and alcohol and substance use disorders. The patient who has risk factors in each of the following three categories - psychosocial, drug-related, and genetic - is at the highest risk for prescription drug abuse. For additional guidance, review the AANA’s Analgesia and Anesthesia for Substance Use Disorder Patient.
- Establish a diagnosis, medical necessity, and treatment goals with measurable outcomes, including function, quality of life and activities of daily living.
- Complete informed consent and treatment agreement (see the “Informed Consent and Treatment Agreement” section above). The agreement should also include the patient’s consent to random drug screens.
• Provide patient education regarding prescription management, security of medications, and the risk of overdose and potential for substance use disorder.
• Work with the patient and their family to set realistic expectations and goals for opioid therapy as well as reasonable expectations about opioid risks.
• Use opioids at lowest effective dosage and shortest duration of time to achieve adequate pain management.
• Regularly assess risks and benefits after starting treatment or increasing a dose. If risks outweigh benefits or if the patient violates the pain management treatment agreement, make appropriate changes to therapy (e.g., taper or discontinue the opioid while avoiding withdrawal symptoms).
• Conduct adherence monitoring for therapeutic outcomes and misuse, abuse, or development of opioid use disorder. Techniques may include qualitative and confirmatory urine drug testing (UDT); consulting PDMP before each prescription; medication reconciliation or “pill counts” and behavioral assessments. Periodic administration of questionnaires, such as Current Opioid Misuse Measure, Pain Assessment and Documentation Tool, or Pain Medication Questionnaire, can also be helpful in adherence monitoring.
• In conjunction with an opioid prescription, consider prescribing naloxone hydrochloride and providing patient instructions for use to mitigate the risk of overdose death.

For additional guidance regarding opioid therapy, review the following guidelines and resources:

• [About CDC’s Opioid Prescribing Guideline](#) (Web resource)
• [CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016](#)
• [Model Policy for the Use of Controlled Substances for the Treatment of Pain Federation of State Medical Boards of the United States, Inc.](#)
• [HHS Pain Management Best Practice](#)
• [American Pain Society/American Academy of Pain Medicine Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain](#)
• [VA/DoD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain](#)
• [WHO Opioid Overdose Guidelines](#)
• [WHO Guidelines for Managing Chronic Pain in Pediatric Patients](#)
• The American Academy of Family Physician’s [Chronic Pain Toolkit](#)

### g. Intervenional Therapeutic Techniques

Intervenional procedures may be indicated in the management of chronic pain in conjunction with or following non-pharmacologic and/or pharmacologic treatment modalities. These techniques may be performed in a prognostic, diagnostic, or therapeutic manner and include, but are not limited to: musculoskeletal injections...
(appendicular and spinal), neuraxial injections, nerve injections, sympathetic nerve blockade, intravenous therapies, chemical neurolysis, neuroablative techniques, biologic and regenerative therapies, and neuromodulation therapies.

h. Ongoing Assessment and Evaluation
Monitor, measure, and evaluate the patient’s pain, functionality, and response to the treatment plan and adjust the treatment plan accordingly.

i. Safety
Patient and healthcare provider safety are paramount. CRNAs integrate safety into the delivery of care and adhere to standards, guidelines, applicable law, and facility policies. Chronic pain management practice incorporates confirmation of patient’s identity; site, procedure, and consent verification, and site marking; appropriate patient monitoring; procedure time-out; universal infection prevention and control precautions; safe injection practices; and radiation safety. For additional guidance, review the AANA’s Standards for Nurse Anesthesia Practice, Patient-Centered Perianesthesia Communication, Infection Control and Prevention Guidelines for Anesthesia Care, and Safe Injection Guidelines for Needle and Syringe Use.

3. Imaging Technology
Ultrasound, fluoroscopy, CT guidance, magnetic resonance imaging (MRI), and emerging imaging technology, such as neuroimaging, may be used, as appropriate, to enhance patient safety and accuracy of invasive diagnostic and therapeutic procedures.

4. Documentation
Document pertinent information and related activities on the patient’s healthcare record in a legible, timely, accurate, and complete manner. The patient’s record should include: the results of the patient assessment and evaluation; diagnosis with supporting documentation; the patient-specific treatment plan, goals, and objectives; documentation of informed consent; documentation of the procedure and interventions; and images of needle placement, if imaging technology was used. For additional guidance, review the AANA’s Documenting Anesthesia Care. For examples of resources regarding documentation for opioid therapy, see Opioid Prescribing Part 1: A Practical Guide to Appropriate Documentation and Opioid Prescribing Part 2: Appropriate Documentation of Follow-up Visits.

5. Telehealth
Telehealth has become one of the key strategies to improve access to pain management services and promote self-management, especially in rural/remote and resource-poor settings. Research shows that patients derive many benefits from the pain management services via telehealth, such as improvements in pain acceptance, pain interference, overall function, mood, and physical activity. Patients with access to telehealth also report high satisfaction with care and lower healthcare costs. According to Currie et al.’s study, telehealth would be more beneficial to the patient if it supplemented traditional in-person care rather than completely replacing it.
6. Continuous Quality Improvement
CRNAs demonstrate continued competency in chronic pain management and treatment, including procedures performed and technology employed. CRNAs engage in continuous quality improvement by using performance metrics, collecting relevant data, and monitoring performance outcomes. For additional guidance, review the AANA’s Standards for Nurse Anesthesia Practice, Scope of Nurse Anesthesia Practice, Clinical Privileges and Other Responsibilities of Certified Registered Nurse Anesthetists, and Continued Competency.

Barriers to Chronic Pain Management Services

Despite a growing number of people in need of chronic pain care, access to these services remains challenging, especially in rural and resource-poor areas. Several barriers to access to chronic pain services identified in the literature are presented in Table 1 below. The CRNA should be aware of these barriers and advocate for their patients, when possible.

Table 1. Barriers to Access Chronic Pain Services

<table>
<thead>
<tr>
<th>Patient-related</th>
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<tbody>
<tr>
<td>• Transportation (e.g., distance to travel, cost of travel, lack of transportation)</td>
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<td>• Out-of-pocket expenses (e.g., high cost of treatment, lack of insurance coverage)</td>
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<td>• Poor health literacy</td>
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<td>• Cultural and social beliefs</td>
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<td>• Perceived lack of treatment efficacy</td>
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<td>• Lack of motivation</td>
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<td>• Lack of support from a healthcare professional/family</td>
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<th>Clinician-related</th>
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<tr>
<td>• Lack of time and support</td>
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<td>• Work overload</td>
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<td>• Attitudes and behaviors</td>
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<tr>
<td>• Lack of education and training</td>
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<td>• Late referral</td>
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<th>Healthcare System-related</th>
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<tr>
<td>• Scheduling (e.g., low availability of appointments)</td>
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<td>• Lack of access to pain specialists, particularly in rural areas</td>
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<td>• Pain management is not a priority</td>
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<td>• Lack of equipment</td>
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<td>• Not utilizing clinicians to full scope of practice</td>
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Conclusion

The experience of chronic pain is unique to each patient and involves complex biological, psychological, and social factors. As part of the interdisciplinary team, CRNAs play an
important role in providing effective pain management services to their patients and contribute to the reduction in the risk of opioid overdose and need for prescription opioids, which may lead to opioid use disorder. Particularly in rural or resource-poor areas, CRNAs may be the only chronic pain specialist providing access to care to these services. CRNAs should recognize barriers to access chronic pain management services and advocate for the patient, when possible.

References


125. Currie M, Philip LJ, Roberts A. Attitudes towards the use and acceptance of eHealth technologies: a case study of older adults living with chronic pain and implications for rural healthcare. BMC Health Serv Res. 2015;15:162.