American Association of
NURSE ANESTHESIOLOGY

November 14, 2022

Via email to: MCC@ahrq.hhs.gov

RE: Request for Information on Person Centered Care Planning for Multiple Chronic Conditions (MCC)

Dear Ms. Collum:

The American Association of Nurse Anesthesiology (AANA) welcomes the opportunity to submit comments to the Request for Information on Person Centered Care Planning for Multiple Chronic Conditions (MCC). We are firmly committed to working with the agency and other healthcare stakeholders to help achieve our common goals of increasing access to healthcare, advancing health equity, increasing innovative healthcare models, reducing regulatory burdens on stakeholders, empowering consumers and making healthcare more affordable for all Americans. The AANA makes the following comments and recommendations:

- Partner with the AANA and CRNAs as Acute and Chronic Pain Experts in MCC Policy Development
- Include Strategic Consideration of the Role of Anesthesia in Enhanced Recovery after Surgery Protocol as an Innovative Healthcare Delivery Model

Background of the AANA and CRNAs

The AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists (SRNAs). AANA membership includes more than 59,000 CRNAs and SRNAs, representing about 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who personally administer more than 50 million anesthetics to patients each year

in the United States and are among the nation's most trusted professions according to Gallup[1]. Nurse anesthetists have provided anesthesia in the United States for 150 years, and high-quality, cost-effective CRNA services are 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. CRNAs also play an essential role in assuring that rural America has access to critical anesthesia services, often serving as the sole anesthesia provider in rural hospitals, affording these facilities the capability to provide many necessary procedures.

CRNAs are involved in every aspect of anesthesia services including 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 and recovery. CRNAs also provide acute, chronic, and interventional 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. Nurse anesthesia predominates in Veterans Hospitals and in the U.S. Armed Services. 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.

Numerous peer reviewed studies have shown that CRNAs are safe, high quality and cost effective anesthesia professionals who should practice to the full extent of their education and abilities. According to a May/June 2010 study published in the journal *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.[2] An August 2010 study published in *Health Affairs* showed no differences in patient outcomes when anesthesia services are provided by CRNAs, physicians, or CRNAs supervised by physicians.[3] Researchers studying

[1] Gallup "U.S. Ethics Ratings Rise for Medical Workers and Teachers (December 22, 2020), https://news.gallup.com/poll/328136/ethics-ratings-rise-medical-workers-teachers.aspx

[2] Paul F. Hogan et al., "Cost Effectiveness Analysis of Anesthesia Providers." *Nursing Economic$.* 2010; 28:159-169. http://www.aana.com/resources2/research/Documents/nec_mj_10_hogan.pdf

[3] B. Dulisse and J. Cromwell, "No Harm Found When Nurse Anesthetists Work Without Physician Supervision." *Health Affairs*. 2010; 29: 1469-1475. http://content.healthaffairs.org/content/29/8/1469.full.pdf

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, the internationally recognized authority on evidence-based practice in healthcare.[4] In addition, a study published in *Medical Care* found no measurable impact in anesthesia complications from nurse anesthetist scope of practice or practice restrictions.[5]

The importance of CRNA services in rural areas was highlighted in a study which examined the relationship between socioeconomic factors related to geography and insurance type and the distribution of anesthesia provider type.[6] The study correlated CRNAs with lower-income populations and correlated anesthesiologist services with higher-income populations. Of particular importance to the implementation of public benefit programs in the U.S., the study also showed that compared with anesthesiologists, CRNAs are more likely to work in areas with lower median incomes and larger populations of citizens who are unemployed, uninsured, and/or Medicaid beneficiaries.[7] This information highlights the importance of CRNAs who provide high-quality, evidence-based care to millions of Americans living and working in rural and underserved areas. Allowing them to participate in rural emergency hospitals will increase needed access to care for patients who live in these areas.

I. AANA Request: Partner with the AANA and CRNAs as Acute and Chronic Pain Experts in MCC Policy Development

The AANA agrees that comprehensive, longitudinal, person-centered care planning is central to models of care that deliver high quality care that meet the needs of people at risk for or living with multiple chronic conditions (MCC) and are pleased to help with the agency's work with improving care for people at risk for or living with MCC. Planning care for people at risk for or living with MCC across settings of care,

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[4] Lewis SR, Nicholson A, Smith AF, Alderson P. Physician anaesthetists versus non-physician providers of anaesthesia for surgical patients. *Cochrane Database of Systematic Reviews* 2014, Issue 7. Art. No.: CD010357. DOI: 10.1002/14651858.CD010357.pub2. http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010357.pub2/abstract

[5] Negrusa B et al. Scope of practice laws and anesthesia complications: No measurable impact of certified registered nurse anesthetist expanded scope of practice on anesthesia-related complications. *Medical Care* June 2016, http://journals.lww.com/lww-medicalcare/Abstract/publishahead/Scope_of_Practice_Laws_and_Anesthesia.98905.aspx.

[6] Liao CJ, Qurashi JA, Jordan LM. Geographical Imbalance of Anesthesia Providers and its Impact on the Uninsured and Vulnerable Populations. Nurs Econ. 2015;33(5):263-270. http://www.aana.com/resources2/research/Pages/NursingEconomics2015.aspx

[7] Liao, op cit.

including existing models of person-centered care, can be achieved through partnerships and an ongoing dialogue between the program, enrollees and providers, such as CRNAs. 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 educational preparation, CRNAs are required to learn and demonstrate competence in the management of pain, a critical component in the delivery of anesthesia care.[8] CRNAs are thought leaders in this area and their practice and experience in treating patients with MCC will help drive solutions for patients suffering from multiple chronic conditions, including chronic pain and mental health issues such as depression and substance use disorder (SUD).

As a main provider of anesthesia and pain management services and as Advanced Practice Registered Nurses (APRNs), CRNAs are uniquely skilled to provide both acute and chronic pain management in a patient centered, compassionate and holistic manner across the pain continuum in all clinical settings (e.g., hospitals, ambulatory surgical centers, offices, and pain management).[9] CRNAs provide acute, chronic, and interventional pain management services, and many patients rely on CRNAs as their primary pain specialist. In addition, CRNAs play an essential role in ensuring that rural America has access to critical anesthesia and pain management services, including critical obstetrical anesthesia services, often serving as the sole anesthesia provider in rural hospitals, affording these facilities the capability to provide many necessary procedures.

From entry into practice education and certification through ongoing education and skills acquisition throughout their career, CRNAs provide robust, patient-centered acute and chronic pain management services. The Council on Accreditation of Nurse Anesthesia Educational Programs (COA) requires acute and chronic pain management content in the curriculum of the 130-accredited nurse anesthesia educational

[8] AANA Chronic Pain Management Guidelines, September 2014, available at: http://www.aana.com/resources2/professionalpractice/Pages/Chronic-Pain-Management-Guidelines.aspx

[9] AANA Chronic Pain Management Guidelines. Nov. 2021, https://www.aana.com/docs/defaultsource/practice-aana-com-web-documents-(all)/professional-practice-manual/chronic-pain-managementguidelines.pdf?sfvrsn=d40049b1_8, AANA Regional Anesthesia and Analgesia Techniques - An Element of Multimodal Pain Management, Practice Considerations. Apr 2018. https://www.aana.com/docs/defaultsource/practice-aana-com-web-documents-(all)/professional-practice-manual/regional-anesthesia-and-analgesiatechniques-an-element-of-multimodal-pain-management.pdf, AANA A Holistic Approach to Pain Management: Integrated, Multimodal, and Interdisciplinary Treatment, Position Statement. July 2016. https://www.aana.com/docs/default-source/practice-aana-com-web-documents-(all)/professional-practicemanual/a-holistic-approach-to-pain-management-integrated-multimodal-and-interdisciplinary-treatment.pdf

programs.[10] The National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA) offers a voluntary nonsurgical pain management (NSPM) subspecialty certification for CRNAs.[11] Additionally, for lifelong learning, the AANA offers CRNAs a continuum of educational resources for pain management practice. These resources include advanced acute and chronic pain management workshops for CRNAs to enhance their skills to improve quality of life and to mitigate complications associated with opioid use and misuse. The AANA, State Nurse Anesthetist Associations, universities and other stakeholders play an active role in CRNA education and professional development, reinforcing how to safely integrate and, when appropriate, eliminate opioids in acute and chronic pain management. Professional development opportunities include educational webinars, online continuing education, conferences, and peer reviewed publications. Additionally, Texas Christian University, the University of South Florida, and Middle Tennessee School of Anesthesia offer fellowships to CRNAs seeking to further specialize in this field.

In addition, CRNAs, as anesthesia professionals, are educated and trained to administer ketamine both for sedation and general anesthesia, chronic pain management and also ketamine infusion therapy for psychiatric disorders and chronic pain. Ketamine infusion clinics are becoming more available, and this therapy has been shown to have antidepressive properties and is increasingly becoming used to treat psychiatric disorders, including major depressive disorder (MDD), bipolar disorder, treatment-resistant depression, and post-traumatic stress disorder (PTSD). The AANA supports a patient-centered, interdisciplinary approach to managing patients who suffer from psychiatric disorders and may benefit from ketamine infusion therapy and practice in accordance with professional ethics, scope and standards of practice, sound professional judgment, available evidence, interests of the patient, and applicable law. When administering ketamine for the treatment of psychiatric disorders, CRNAs collaborate with healthcare professionals whose practice includes focusing on and diagnosing mental health and psychiatric disorders within their professional and state scope of practice.[12] As part of the collaboration, CRNAs may obtain a

[10] Council on Accreditation of Nurse Anesthesia Educational Programs. List of Accredited Educational Programs, revised July 2022: https://www.coacrna.org/wp-content/uploads/2022/07/List-of-Accredited-Educational-Programs-July-18-2022-1.pdf

[11] National Board of Certification and Recertification for Nurse Anesthetists. Nonsurgical Pain Management Examination: https://www.nbcrna.com/exams/nspm

[12] AANA and APNA Joint Position Statement on Ketamine Infusion Therapy for Psychiatric Disorders (2019), https://www.aana.com/docs/default-source/practice-aana-com-web-documents-(all)/professional-practice-manual/apna-aana-joint-statement-on-ketamine.pdf?sfvrsn=8ecfb9bb_10

referral to provide ketamine infusion therapy for psychiatric disorders. The CRNA's role in ketamine infusion therapy may include, but is not limited to, reviewing healthcare records, obtaining a health history and assessment, performing a history and physical, conducting pre-infusion assessment and evaluation, ordering and evaluating diagnostic tests, ordering or prescribing medications, initiating the infusion, monitoring the patient, conducting post-infusion assessment and evaluation, and managing infusion-related adverse events or complications.[13]

Furthermore, CRNAs have been on the front lines of developing novel non-opioid based treatments for both chronic and acute pain and we support maximum flexibility in allowing pain treatment plans that rely on the clinical judgment of the practitioner directing care. CRNA chronic pain management practitioners address chronic pain through the use of a multimodal approach that includes opioid sparing or no opioid pharmacologic and non-pharmacologic pain mitigation strategies. As the risk of opioid dependence and addiction begins with the first exposure, CRNAs promote comprehensive multimodal pain management in addition to Enhanced Recovery After Surgery (ERAS®) protocols (that we will outline more below) as non-opioid alternatives to treat pain in all clinical settings. Many pharmacologic treatments can be used to manage pain. While each nonopioid alternative has its own indications and risks, some are likely to be as effective as opioids or more so for reducing pain associated with the conditions for which they are indicated and when used appropriately, carry lower risk of adverse outcomes**.** Careful assessment, evaluation, and treatment of acute pain, with appropriate prescribing of an opioid, may prevent access to unused opioids and development of opioid dependency and abuse.

Multimodal analgesia describes the use of more than one modality or techniques to achieve effective pain control from the preoperative period through initial recovery and return home.[14] A multimodal, instead of the traditional unimodal opioid approach involves the administration of several analgesics with separate mechanisms of action across the perioperative period and/or concurrent field block using local anesthetic, regional or neuraxial analgesia (e.g., paravertebral block with non-opioid analgesia).[15] It is important to take into consideration the complexity of the surgical procedure, patient pain experience history and preferences, anticipated level of postoperative pain, and duration of action of analgesics and local anesthetics when

[13] AANA and APNA Joint Position Statement on Ketamine Infusion Therapy for Psychiatric Disorders op. cit

[14]. Optimizing pain management to facilitate Enhanced Recovery After Surgery pathways. *Can J Anaesth.* Feb 2015;62(2):203-218.
[15] Tan M, Law LS, Gan TJ, op cit.

deciding on pain management options for pathway development and for individual patients. Multimodal analgesia may eliminate or significantly reduce the use of opioids and adverse side effects such as respiratory depression, postoperative nausea and vomiting (PONV), and delayed return of gastrointestinal function.[16]

Non-opioid medications include acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDs), systemic lidocaine or ketamine infusion, long-acting local anesthetics, and gabapentinoids (gabapentin/pregabalin).[17] Other modalities using local anesthetics of varying durations of action include surgical site local anesthetic infiltration, field blocks (e.g., transversus abdominis plane (TAP) block), central neuraxial techniques (e.g., epidural and spinal analgesia), and regional blocks.[18] Non-pharmacological analgesia (e.g., acupuncture, music therapy) as well as cognitive-behavioral techniques (e.g., guided imagery, relaxation), may be used as an adjunct to pharmacological methods to support the patient to reduce postoperative pain, anxiety, and use of pain medication.[19,20]

CRNAs have expertise in many areas that may be provided to patients with MCC, and both the AANA and our CRNA members would be happy to partner with the agency in providing advice on policies affecting the provision of these and related services. As the agency looks to create future policies to help patients with multiple chronic conditions, including chronic pain, SUD, mental health related issues, we request that CRNAs be used as a resource in policy development.

II. AANA Request: Include Strategic Consideration of the Role of Anesthesia in Enhanced Recovery after Surgery Protocol as an Innovative Healthcare Delivery Model

One example of an innovative models of care that could support clinicians and practices in routinely engaging in comprehensive, longitudinal, person-centered care planning to improve the care of people at risk for or living with MCC is the use of techniques such as anesthesia enhanced recovery after surgery (ERAS®) programs. CRNAs have an abundance of experience and training in the pain realm, including

[16] Miller ET, Gan TJ, Thacker JK. Enhanced Recovery pathways for major abdominal surgery *Anesthesiology News* 2014.
[17] Siu-Chun Law L, Ah-Gi Lo E, Gan TJ. Preoperative Antiemetic and Analgesic Management In: Gan TJ, Thacker JK, Miller TE, Scott MJ, Holubar SD, eds. *Enhanced Recovery for Major Abdominopelvic Surgery.* West Islip, NY: Professional Communications, Inc; 2016:105-120.
[18] Montgomery R, McNamara SA. Multimodal Pain Management for Enhanced Recovery: Reinforcing the Shift From Traditional Pathways Through Nurse-Led Interventions. *AORN J.* Dec 2016;104(6S):S9-S16.
[19] Tan M, Law LS, Gan TJ, op cit.
[20] Montgomery R, McNamara SA, op cit

providing anesthesia and acute, chronic and interventional pain management services. As CRNAs personally administer more than 50 million anesthetics to patients each year in the United States, CRNA services are crucial to the successful development and implementation of the use of techniques such as ERAS® programs. An increasing number of procedures are utilizing non-operating room anesthesia (NORA) and protocols that allow for the use of techniques that help patients recover more quickly and eliminate the use of opioids and the complications they bring.[21] A clinician's judgement, experience and knowledge are important aspects of providing patient care safely and goes towards the quality of care patients receive.[22]

ERAS® is a patient-centered, evidence-based, pain management strategy employed by CRNAs to reduce the need for opioids, improve patient outcomes and reduce costs.[23] Using specific protocol-driven enhanced recovery after surgery pathways improves patient outcomes by reducing the patient's stress response to surgery, shortening the overall hospital length of stay, and accelerating the return to normal daily function. For example, the enhanced recovery pathway for total hip arthroplasty engages the entire perioperative team with the patient to limit care variation that improves outcomes and patient satisfaction. A total hip arthroplasty that includes minimally invasive surgical techniques and multimodal pain management with motor sparing regional anesthesia allow the patient to eat, drink and walk/exercise soon after recovery from anesthesia. The patient's pain management plan of care begins pre-procedure and continues through post-discharge using techniques such as regional anesthesia including placement of epidural catheters, targeted peripheral nerve blocks, non-pharmacologic approaches, and non-opioid based pharmacologic measures.

As ERAS® protocols have been implemented, patient engagement in their own plan of care has improved return to pre-procedure health on the day of surgery. CRNAs play an integral role in these episodes of care, in both inpatient and outpatient settings, as proper anesthesia services management can make a tremendous difference in terms of improving patient flow, patient safety, and ultimately in cost savings.[24] Conversely,

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[21] Non-operating room anesthesia: Is it worth the risk? Bruce J. Leone Current Anesthesiology Reports volume 10, pages449–455 (2020). Available at https://link.springer.com/article/10.1007/s40140-020-00423-4.

[22] Non-Operating Room Anesthesia: Patient Selection and Special Considerations. Local Reg Anesth. 2020; 13: 1–9. Published online 2020 Jan 8. doi: 10.2147/LRA.S181458. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6956865/.

[23] AANA Enhanced Recovery After Surgery, http://www.future-of-anesthesia-care-today.com/pdfs/eras-info.pdf.

[24] See for example Rice AN, Muckler VC, Miller WR, Vacchiano CA. Fast-tracking ambulatory surgery patients following anesthesia. J Perianesth Nurs. Apr 2015;30(2):124-133. Also see Kimbrough CW et al. Improved Operating Room Efficiency via Constraint Management: Experience of a Tertiary-Care Academic Medical Center. *Journal of the American College of Surgeons* 2015; 221: 154-162.

research shows that suboptimal care in the preoperative, intraoperative, or postoperative phases of surgery may compromise care, resulting in poor patient outcomes and unnecessarily higher healthcare costs.[25] Facility and population specific ERAS® protocols engages the patient and the multidisciplinary team in the plan of care and continued assessment of patient status to optimize care, decrease complications, decrease time to discharge, improve outcomes and lower cost of care by limiting variation in care. CRNAs provide many ERAS® elements of care to optimize the patient to return to normal activity and diet, including minimally invasive surgical techniques, giving the patient a carbohydrate beverage at least two hours before surgery, maintaining patient warmth during the procedure and also providing multimodal pain management services to minimize or eliminate use of opioids. We urge that the agency emphasize the strategic consideration of the role of anesthesia delivery that is safe and cost-efficient and include the use of techniques such as ERAS® programs, which help reduce costs and improve patient outcomes.[26]

The AANA appreciates the opportunity to comment on this RFI on Person Centered Care Planning for Multiple Chronic Conditions. Should you have any questions regarding our comments, please feel free to contact AANA Senior Associate Director, Federal Regulatory and Payment Policy, Randi Gold at rgold@aana.com.

Sincerely,

Angela Mund, DNP, CRNA
AANA President

cc: William Bruce, MBA, CAE, AANA Chief Executive Officer
Lorraine Jordan, PhD, CRNA, CAE, FAAN, AANA Chief Advocacy Officer
Randi Gold, MPP, AANA Senior Associate Director Federal Regulatory and Payment Policy

[25] Miller TE, Roche AM, Mythen M. Fluid Management and Goal-Directed Therapy as an Adjunct to Enhanced Recovery After Surgery (ERAS). *Canadian Journal of Anesthesia* 2015; 62 (2)" 158-168.

[26] See for example Boulind CE, Yeo M, Burkill C, et al. Factors predicting deviation from an enhanced recovery programme and delayed discharge after laparoscopic colorectal surgery Colorectal Dis. 2011;14:103-110; Miller TE, Thacker JK, White WD, et al. Reduced length of hospital stay in colorectal surgery after implementation of an enhanced recovery protocol. Anesth Analg. May 2014;118(5):1052-1061; and Enhanced recovery care pathway. A better journey for patients seven days a week and better deal for the NHS. National Health Service 2012-2013. http://www.nhsiq.nhs.uk/resource-search/publications/enhanced-recovery-care-pathway-review.aspx. Accessed February 25, 2015.