AANA
American Association of
NURSE ANESTHESIOLOGY

Electronic Submission via: https://acumen.qualtrics.com/jfe/form/SV_0qB0oApVFxbj8tU

Acumen LLC

To Whom It May Concern:

The AANA welcomes the opportunity to comment on the Wave 5 Measure Development feedback survey. We thank the Centers for Medicare & Medicaid Services (CMS) and Acumen for considering anesthesia care as a clinical candidate area and for allowing CRNAs to participate in panels and subcommittees on previous Waves. Our comments are focused on the survey questions on anesthesia care, cross-cutting questions for wave 5 candidate groups, and participating on Wave 5 development.

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 included 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

[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

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 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

---

[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

internationally recognized authority on evidence-based practice in healthcare.[4] Most recently, a study published in *Medical Care* (June 2016) 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 recent 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.

[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.

4.1.1 Anesthesia Care

Response to Question 1: Previous stakeholder feedback has identified some anesthesia-related complications such as airway injury from intubation, untreated hypothermia, and nerve injury for a peripheral block. Since these may be infrequent, are there other services for complications or other follow-up care that could differentiate good care from poor care? That is, if a cost measure is centered on anesthesia services for a type of surgery, what sort of complications and other follow-up services may be reasonably influenced by the clinician providing the anesthesia services rather than the surgeon alone?

We believe that the episode group measures should accurately account for the true cost of providing anesthesia care services and should accurately attribute anesthesia care services to the proper clinician. Typically, complications around anesthesia happen within 24 to 48 hours after surgery; therefore, the attribution of complications should be limited to the perioperative setting. We believe it is critical that CRNAs should not be responsible for overall surgical complications that are unrelated to anesthesia.

One area of service that may be reasonably influenced by the clinician providing the anesthesia services rather than the surgeon is the use of techniques such as anesthesia enhanced recovery after surgery (ERAS®) programs. 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.[8] 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 allows 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

[8] AANA Enhanced Recovery After Surgery, https://www.aana.com/practice/clinical-practice-resources/enhanced-recovery-after-surgery.

regional anesthesia including placement of epidural catheters, targeted peripheral nerve blocks, non-pharmacologic approaches, and non-opioid based pharmacologic measures.

As ERAS® pathways have been implemented, patient engagement in their own plan of care has improved return to preprocedure 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.[9] Conversely, 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.[10] 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.

Response to Question 2: Should we develop a broad anesthesia measure for all types of procedures, or would it be better to develop something narrower (e.g., anesthesia for joint replacement)? If a narrower measure is preferred, what scope of services would help capture anesthesia care services provided by anesthesiologists and CRNA broadly? If a broad measure is preferred, would sub-grouping by procedure type be useful? What categorization of procedure type would be clinically coherent for a broad anesthesia measure?

[9] 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.

[10] 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.

While an argument could be made for both the development of a narrower or a broader measure, we believe a broader measure would be better to develop. Under the broader umbrella, ERAS, as outlined above, would apply to a substantial share of anesthesiologists and CRNAs.

Response to Question 3: What other related services, besides injections, could be included in an interventional pain management measure? For example, if injections are not successful at managing pain, what would a clinician focusing on pain management care provide as the next line of treatment? What sorts of services would a patient with poorly managed pain receive that would be different in frequency or intensity than a patient with well-managed pain?

Interventional pain management is distinct from surgical pain management. Interventional pain management requires the use of multimodal pain multimodal pain management that "addresses the full range of an individual patient's biopsychosocial challenges, by providing a range of multiple and different types of therapies that may include medical, surgical, psychological, behavioral, and integrative approaches as needed."[11] CRNAs who provide interventional pain management provide comprehensive patient-centered pain management to optimize recovery. CRNAs practice in accordance with their professional scope of practice, federal and state law, guidelines, and facility policy to provide acute and chronic pain management services. As an example of employing techniques outside of injections, it is not uncommon for CRNA chronic pain management practitioners to provide the placement and management of nonsurgical neurostimulating systems. In addition, CRNAs may perform drug screenings or may order services such as physical therapy and imaging. While these are not an exhaustive list of the services that a CRNA performing interventional pain management may utilize, these examples show the vast range of services that could be provided.

Response to Question 4: Should a measure on interventional pain management focus on acute pain management (e.g., local anesthetics such as facet injections), chronic pain management (e.g., local pain intervention such as treatments for tendonitis or carpal tunnel), or both? Using claims data, what approaches could we consider to help identify chronic versus acute interventional pain management?

[11] National Academy of Medicine. 2011. Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research. Washington, DC: The National Academies Press.

We find that acute pain management would be surgically related while chronic pain management would be related to non-surgical pain or to chronic pain resulting after surgery. This should be very easy to differentiate using claims data.

5.1 Cross-Cutting Questions for All Wave 5 Candidate Episode Groups

Response to Opportunity for improvement: What kinds of services can reflect that the candidate episode group has sufficient opportunities for improvement? For example, cost measures generally include services reflecting variation in treatment options, intensity/duration, follow-up care, complications, and more.

Determining which procedural episode group, by CPT and Trigger codes, could benefit from regional anesthesia given for acute pain management and or ERAS® protocols, crossed referenced with actual techniques used, could potentially lead to measures reflecting variation in treatment options, intensity/duration, follow-up care and complications. The challenge with this is to accurately capture these elements tied to anesthesia services. There can be a lot of variability in patients who undergo the same type of procedure in terms of intensity and duration, patient physical status factors, and follow-up care and complications will be given the same types of procedures. We believe it is possible to capture patients with similar characteristics, but there may be issues with not having several large populations with the same characteristics.

Response to Trigger codes: Trigger codes define the patient cohort for the measure. The preliminary set of draft trigger codes we propose is in the accompanying Preliminary Specifications of Wave 5 Candidate Episode Groups workbook. We solicit comment on this list of draft trigger codes to help inform the patient cohort. What modifications can we apply to these draft trigger codes to ensure a measure represents a clinically coherent patient cohort and also sufficient impact and coverage?

Identifying a trigger code that could benefit from regional anesthesia performed by an anesthesia provider and or ERAS® protocols used could be beneficial and measurable. However, while trigger codes in concept are a good idea, they are not always practical. As an example, many

anesthesia providers go to work to perform an anesthetic. The anesthesia billing department staff will submit a bill for the service provided. In one instance, the patient has an issue such as hypothermia, but that issue is not reflected in the initial submitted bill as no trigger code is submitted. The issue becomes tricky as it is not clear who is responsible for submitting this code and how that trigger code would be linked to the provider. Furthermore, the question is whether it is appropriate to submit a trigger code about an issue the anesthesia provider has no idea is being submitted and potentially being penalized as a result of that trigger code.

Response to Additional concerns: Are there any other concerns that may be present with assessing the care of patients in this clinical area? If so, what are some potential approaches to address these concerns for a cost measure?

We have concerns that there are instances in which the anesthesia provider may be not in full control with respect to the use of ERAS® protocols. For example, if a surgeon or facility is not willing to allow the provider to perform regional anesthesia techniques for post-op pain control or institute ERAS® protocols, anesthesia providers will be limited in what they can measure.

5.2 Participation in Wave 5 Development

Response to Wave 5 Workgroup Composition: Are you interested in participating in Wave 5? You may submit input on which specialties and stakeholders should be considered for the workgroup, as well as contact information for outreach related to clinician expert workgroup composition if anesthesia or interventional pain management is selected for development.

The AANA has members who are interested in participating in Wave 5. The AANA and CRNAs should be included for the anesthesia and interventional pain management clinical expert workgroup composition if these topic areas are selected for development. 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. 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.

For outreach related to clinical expert workgroup composition, please contact Romy Gelb-Zimmer, Senior Associate Director, Federal Regulatory and Payment Policy, AANA at rgelb-zimmer@aana.com.

Response to Are you interested in participating in Wave 5: Would you be interested in nominating someone for the workgroup? We will include you in future emails related to the nomination period later in spring 2022 - please include the name and email address of all interested parties.

The AANA would be interested in nominating someone for a workgroup on anesthesia and interventional pain management measures. Please contact Romy Gelb-Zimmer, Senior Associate Director, Federal Regulatory and Payment Policy, AANA at rgelb-zimmer@aana.com on future emails related to the nomination period.

We thank you for the opportunity to comment on this survey. Should you have any questions regarding these matters, please feel free to contact the AANA Senior Director of Federal Government Affairs, Ralph Kohl, at 202.484.8400, rkohl@aana.com.

Sincerely,

Dina Velocci, DNP, CRNA, APRN
AANA President

cc: David Hebert, JD, AANA Interim Chief Executive Officer
Ralph Kohl, AANA Senior Director of Federal Government Affairs
Romy Gelb-Zimmer, MPP, AANA Senior Associate Director Federal Regulatory and Payment Policy