American Association of
NURSE ANESTHESIOLOGY

July 13, 2022

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8010
Baltimore, MD 21244-1850

RE: Centers for Medicare and Medicaid Services (CMS) Behavioral Health Strategy

Dear Ms. Brooks-LaSure:

The American Association of Nurse Anesthesiology (AANA) is writing to offer our support to the agency's recently released Behavioral Health Strategy. We have appreciated our long and fruitful relationship with the agency, and we appreciate and support efforts to remove barriers that limit healthcare professionals, such as CRNAs, from practicing at the top of their license and scope of practice. We are committed to our continued work with the agency to help reduce barriers to CRNA practice and ensuring patients have access to timely, cost effective and high-quality anesthesia care. Our comments pertain to Goal 3 of the Behavioral Health Plan; Ensure effective pain treatment and management and include:

I. Include Strategic Consideration of the Role of Anesthesia in Enhanced Recovery after Surgery Protocol as an Innovative Healthcare Delivery Model
II. Use of Non-Opioid Alternatives, Such as Multi-Modal Pain Management ERAS® Protocols, Do Lead to a Decrease in Prescription Opioid Use and Addiction
III. Recommend Inclusion of CRNAs, who are Skilled and Educated in Pain Management, with Development of Report to Congress on Pain Management

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

[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

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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 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

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[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

[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.

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

The AANA supports the agency's goal through this plan of increasing to prevention and treatment services for substance use disorders, mental health services, crisis intervention and pain care; and further enable care that is well-coordinated and effectively integrated. CRNAs have an abundance of experience and training in the pain realm, including 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 anesthesia enhanced recovery after surgery (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.[8] A clinician's judgement, experience and knowledge are important aspects of providing patient care safely and goes towards the quality of care patients receive.[9]

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.[10] 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.

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[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.

[8] 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.

[9] 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/.

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

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.[11] 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.[12] 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.[13]

II. Use of Non-Opioid Alternatives, Such as Multi-Modal Pain Management ERAS® Protocols, Leads to a Decrease in Prescription Opioid Use and Addiction

The AANA supports the agency's goal of reducing disparities in health and health care among patients to improve access to high quality, affordable, person-centered behavioral health care, and ensure parity in access, coverage, and treatment for substance use disorders and mental health services. We also support engaging healthcare providers to address both substance use disorder and mental health needs of individuals, families, and communities. 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.

As a main provider of pain management services in all types of settings, 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.[14] Furthermore, the approach that CRNA pain management

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[11] 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.

[12] 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.

[13] 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.

[14] AANA Chronic Pain Management Guidelines, September 2014, available at: http://www.aana.com/resources2/professionalpractice/Pages/Chronic-Pain-Management-Guidelines.aspx, AANA Regional Anesthesia and Analgesia Techniques - An Element of Multimodal Pain Management Guidelines, https://www.aana.com/docs/default-source/practice-aana-com-web-documents-(all)/regional-anesthesia-and-analgesia-techniques-an-element-of-multimodal-pain-management.pdf?sfvrsn=8aac5eb1_6, and AANA Guidelines on

practitioners employ when treating their chronic pain patients may reduce the reliance on opioids as a primary pain management modality, thus aiding in the reduction of potential adverse drug events related to opioids.

As the risk of opioid dependence and addiction begins with the first exposure, we recommend that CMS promote comprehensive multimodal pain management in addition to the ERAS® protocols that we have already discussed in the preceding section as a non-opioid alternative 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.

Interventional pain management involves the use of invasive techniques, such as joint injections, nerve blocks, spinal cord stimulation, and other procedures, to reduce pain. Such techniques are best performed in the context of a multimodal treatment regimen, including physical therapy to maximize functional restoration. There has been a significant increase in the volume of certain interventional procedures over the past 10 years, much of it focused on low back and neck pain with or without radiation to the hip and other lower extremities.[15]

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.[16] 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).[17] 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 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.[18]

Non-opioid medications include acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDs), systemic lidocaine or ketamine infusion, long-acting local anesthetics, and gabapentinoids (gabapentin/pregabalin).[19]

A Holistic Approach to Pain Management: Integrated, Multimodal, and Interdisciplinary Treatment https://www.aana.com/docs/default-source/practice-aana-com-web-documents-(all)/a-holistic-approach-to-pain-management-integrated-multimodal-and-interdisciplinary-treatment.pdf?sfvrsn=f40049b1_4

[15] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Sciences Policy; Committee on Pain Management and Regulatory Strategies to Address Prescription Opioid Abuse; Phillips JK, Ford MA, Bonnie RJ, editors. Pain Management and the Opioid Epidemic: Balancing Societal and Individual Benefits and Risks of Prescription Opioid Use. Washington (DC): National Academies Press (US); 2017 Jul 13. 2, Pain Management and the Intersection of Pain and Opioid Use Disorder. Available from: https://www.ncbi.nlm.nih.gov/books/NBK458655/

[16]. Optimizing pain management to facilitate Enhanced Recovery After Surgery pathways. *Can J Anaesth.* Feb 2015;62(2):203-218.

[17] Tan M, Law LS, Gan TJ, op cit.

[18] Miller ET, Gan TJ, Thacker JK. Enhanced Recovery pathways for major abdominal surgery *Anesthesiology News* 2014.

[19] 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.

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.[20] 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.[21,22]

Using a multimodal approach and specific protocol-driven ERAS® 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. The anesthesia professional plays a pivotal role in patient/family education by engaging the patient as an active participant in his or her care and the recovery process.[23] Anesthesia professionals continue to build on these activities throughout the Prehospital/Preadmission Phase through patient assessment and evaluation to identify unique elements of the patient's health, pain and anesthesia history that may require modification of the ERAS® pathway to coordinate development of the plan of care with the patient and their primary care and specialty team, as appropriate. The patient's pain management plan of care begins pre-procedure and continues through post-discharge using opioid-sparing techniques such as regional anesthesia including placement of epidural catheters, targeted peripheral nerve blocks, non-pharmacologic approaches, and non-opioid based pharmacologic measures. Collaboration with the patient's advanced pain management team and utilizing multi-modal pain management strategies can improve outcomes, especially for patients with difficult to control pain (e.g., chronic pain patient, substance use disorder).[24,25, 26] A clinician's judgement, experience and knowledge are important aspects of providing patient care safely and goes towards the quality of care patients receive.[27]

III. Recommend Inclusion of CRNAs, who are Skilled and Educated in Pain Management, with Development of Report to Congress on Pain Management

Due to the extensive experience CRNAs have with pain management services, we ask that as the agency include CRNAs in the development of a report to Congress that includes information on acute and chronic pain, help in understanding the current landscape of pain relief options for Medicare beneficiaries, and inform decisions about payment and overage for pain management interventions. CRNAs provide safe and high-quality anesthesia and pain related care for patients of all ages in all communities across the United States. By virtue of education and individual clinical experience and competency, a CRNA may practice

[20] 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.
[21] Tan M, Law LS, Gan TJ, op cit.

[22] Montgomery R, McNamara SA, op cit

[23] Brady KM, Keller DS, Delaney CP. Successful Implementation of an Enhanced Recovery Pathway: The Nurse's Role. *AORN J.* Nov 2015;102(5):469-481.
[24] Vadivelu N, Mitra S, Kaye AD, Urman RD. Perioperative analgesia and challenges in the drug-addicted and drug-dependent patient. *Best Pract Res Clin Anaesthesiol.* Mar 2014;28(1):91-101.
[25] Shah S, Kapoor S, Durkin B. Analgesic management of acute pain in the opioid-tolerant patient. *Curr Opin Anaesthesiol.* Aug 2015;28(4):398-402.

[26] Pulley DD. Preoperative Evaluation of the Patient with Substance Use Disorder and Perioperative Considerations. *Anesthesiol Clin.* Mar 2016;34(1):201-211.
[27] 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/.

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.[28]

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 120-accredited nurse anesthesia educational programs.[29] The National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA) offers a voluntary nonsurgical pain management (NSPM) subspecialty certification for CRNAs.[30] 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.

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

Sincerely,

Dina Velocci, DNP, CRNA, APRN
AANA President

cc:	William Bruce, MBA, CAE, AANA Chief Executive Officer
	Ralph Kohl, BA, AANA Senior Director of Federal Government Affairs
	Randi Gold, MPP, AANA Senior Associate Director Federal Regulatory and Payment Policy

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

[29] Council on Accreditation of Nurse Anesthesia Educational Programs. Standards for Accreditation of Nurse Anesthesia Programs – Practice Doctorate, revised October 2019: https://www.coacrna.org/wp-content/uploads/2020/01/Standards-for-Accreditation-of-Nurse-Anesthesia-Programs-Practice-Doctorate-revised-October-2019.pdf

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