April 1, 2019

Vanila M. Singh, MD, MACM
Chief Medical Officer
Office of the Assistant Secretary for Health
U.S. Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201


Dear Dr. Singh,


The Academy serves the public and the nursing profession by advancing health policy and practice through the generation, synthesis, and dissemination of nursing knowledge. The Academy’s more than 2,700 fellows are nursing’s most accomplished leaders in education, management, practice, and research. They have been recognized for their extraordinary contributions to the promotion of the public’s health through evidence and innovation.

Consistent evidence has demonstrated the ability of advanced practice registered nurses (APRNs; including nurse practitioners (NPs), certified nurse-midwives, certified registered nurse anesthetists (CRNAs), and clinical nurse specialists (CNS)) to reduce cost while increasing quality and access to care.\(^1\) Additionally, the recently enacted Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act [Public Law No. 115-271] increased efforts to curb the opioid epidemic and treat substance use disorders (SUDs) by permanently authorizing NPs (as well as physician assistants) and providing a five-year authorization for the other APRN roles to prescribe lifesaving medication-assisted treatments (MATs).\(^2\)

Nurses across the country, and especially in designated health professional shortage areas, are on the frontlines of prevention and treatment of SUDs and are knowledgeable of various pain-management strategies that can be used to reduce inappropriate use of opioid pain medication.

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The Academy appreciates the Task Force for taking the first step toward being inclusive of health professionals who provide pain management care. However, the Academy would like to offer comments on key areas of the draft report where inclusivity of the whole healthcare team could be better defined for clarity. This will help achieve increased access to vital services and the clinicians authorized to provide them.

**Define the Full Health Care Team**

The overall report reads as physician-centric; therefore, the Academy requests the Task Force use inclusive language throughout this report, and in future reports, as appropriate. Throughout the draft recommendation, reference is made to “physicians and other health care providers.” The Academy would like to draw the Task Force’s attention to the Medicare Access and CHIP Reauthorization Act [MACRA, Pub. L. 114-10], which defines MIPS-eligible providers in such a way to include “a physician assistant, nurse practitioner, and clinical nurse specialist...and a certified registered nurse anesthetist” as applicable practitioners. As NPs, CNSs, and CRNAs are included in this definition, they should equally be referenced in the Task Force’s recommendations.

Section 2.2: Medications

**Gap 1, Recommendations 1a, 1c**

These recommendations refer to physicians as the primary provider in treatment and referral. Again, this does not align with the MACRA definition allowing NPs, CNSs, and CRNAs to prescribe and practice to the full extent of their clinical training, in accordance with state laws.

**Gap 3, Recommendation 3a**

This recommendation negates the fact that nurses have historically used a holistic approach in providing safe, high-quality care that is accessible. It is important to include the work that has been, and continues to be, done by nurses in regards to pain management care through non-opioid pain management.

Section 2.4: Intervventional Procedures

**Gap 1, Recommendation 1c; Gap 3, Recommendations 3a-3c**

The Academy, along with our APRN colleagues, request that these recommendations be amended to include APRN education and training as an appropriate path to competence. The use of physician-centric language in this section of the draft report inherently excludes APRNs from being appropriately credentialed to provide the care they have been legally designated to provide. Credentialing and training requirements must be inclusive of the educational pathways taken by APRNs and physician assistants.

In particular, CRNAs have extensive educational and credentialing requirements to receive and maintain licensure. CRNAs must demonstrate competence regarding pain management in order to remain licensed. All CRNAs are certified and recertified to practice by the National Board of Certification and Recertification for Nurse Anesthetists to ensure the education and skill

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development needed is met to provide pain management throughout one’s career. The Academy respectfully requests fellowship training programs for APRNs be available as a recognized alternative to Accreditation Council for Graduate Medical Education-accredited pain medicine programs.

Section 3.3.2: Insurance Coverage for Complex Management Situations
Gap 4, Recommendation 4a
Reimbursement of care should be provided based on the care provided, not on the clinician providing that care. The Academy believes APRNs should be able to practice to the full extent of their education, clinical training, and certification and should be reimbursed as such, especially as health care shifts from provider-based, fee-for-service to team-based, patient-centered care. In this regard, the Academy supports the recommendation that a multidisciplinary reimbursement model be implemented for chronic pain management care. In order for this to achieve the most cost-effective outcomes, electronic health records (EHRs) must also be able to correctly attribute care among all MIPS-eligible providers.

Section 3.3.3: Workforce
Gap 1, Recommendation 1c
The Academy supports the recommendation to “expand the availability of nonphysician specialists” as this would not only provide the opportunity for interprofessional education regarding pain management but also encourage a team-based approach to care. This recommendation is also in line with the 2019 expansion of MIPS-eligible providers. Expansion of the health care team is also a positive step towards achieving accurate provider attestation within EHRs and should lead to further provider-neutral language within future recommendations. However, we do request language in the report remain consistent and refer to other specialists appropriately, refraining from labelling the other members of care team as “nonphysician.”

Thank you for your work to produce the Draft Report on Pain Management Best Practices: Updates, Gaps, Inconsistencies, and Recommendations and for your consideration of these comments. The Academy hopes these comments will be useful for improving access to health care while protecting the health safety of patients impacted by the opioid epidemic. If the Academy can be of assistance, or should you like to discuss these comments further, please do not hesitate to contact Dr. Suzanne Miyamoto, Chief Executive Officer, at smiyamoto@aannet.org.

Sincerely,

Karen Cox, PhD, RN, FACHE, FAAN
President

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