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Linda Porter, PhD
NINDS/NIH
31 Center Drive, Room 8A31
Bethesda, MD 20892

Re: Comments on Draft National Pain Strategy

Dear Dr. Porter,

The American Nurses Association (ANA) welcomes the opportunity to provide comments on the *National Pain Strategy: A Comprehensive Population Health-Level Strategy for Pain*. As the only full-service professional organization representing the interests of the nation's 3.1 million registered nurses (RNs), ANA is privileged to speak on behalf of its state and constituent member associations, organizational affiliates, and individual members. RNs are a critical component to achieving "a cultural transformation in pain prevention, care, education and research," as they serve in multiple direct care, care coordination, and administrative leadership roles, across the full spectrum of health care settings. RNs provide and coordinate patient care, educate patients, their families and other caregivers as well as the public about various health conditions, wellness, and prevention, and provide advice and emotional support to patients and their family members. ANA members also include the four advanced practice registered nurse (APRN) roles: nurse practitioners, clinical nurse specialists, certified nurse-midwives and certified registered nurse anesthetists.

ANA applauds and strongly supports the scope and main elements of the National Pain Strategy as proposed, particularly the emphasis on:

- Prevention and early recognition and intervention in the primary care setting.
- Self-management strategies.
- Large scale education to both the public and healthcare professionals to remove the stigma associated with chronic pain and to improve pain management practice.
- A patient-centered interdisciplinary approach to care.
- Initiatives to remove barriers and increase access to care for vulnerable and at-risk populations.

After review of this document, ANA makes the following recommendations for consideration:

Continue to clarify key concepts and work toward common understanding of key terms. The Strategy provides (Box 1) definitions for terms used in the report. ANA encourages, however, more specific language in the education strategy for the recognition, differentiation and management of

addiction, pseudo-addiction, and chronic pain. Providers need to understand clearly the difference between these conditions and it would be helpful to have them specifically called out.

ANA also encourages the IPRCC to expand and clarify the concept of multimodal pain treatment (included in the Box on p. 9) to include access to medical and procedural treatments, traditional and integrative therapies, psychological evaluation and intervention/treatment, and physical/rehabilitative therapies. The term is an important one that is used several times throughout the document. Having a definition of truly comprehensive pain management practice so that providers, patients and payers know precisely what that entails will help to ensure that patients have access to all evidence- based treatments (not just procedural or medical, depending on the kind of pain management practice a patient accesses).

Strategies to address diversion and abuse of opioids must be effective and not create new, unintended barriers to care. While diversion and abuse of opioids are serious problems, ANA is concerned that these problems have sometimes overshadowed the recognition of pain as a chronic problem. In addition, some of the reactions to the problem of opioid abuse - in particular, limiting the prescriptive authority of APRNs - are misplaced and limit effective treatment for patients. Prescription Monitoring Programs (PMPs) are important tools that can facilitate coordination of care and management and help to prevent abuse and diversion. Specific tracking of opioid prescriptions through electronic monitoring at the regional and national level is an important aspect of the strategy.

In the words of one nurse practitioner, *"We need to address the potential for abuse and addiction up front. If we are ever to be able to prescribe opioids to their best (safe) use we need better ways to track and monitor use at the regional and national level. If prescribers were more confident they would know if patients are clinic and emergency department 'hopping' (signs of abuse and diversion), that might relieve some or most of their concern."*

If strategies to address diversion and abuse of opioids are not addressed early in the process, it will be difficult to dispel the stigma associated with chronic pain for those that require opioids as part of their treatment plan, and to remove barriers that limit access to appropriate and needed pain management care.

The "Pathways to Safer Opioid Use" interactive training tool is an excellent example of concrete deliverables that can help us toward meeting the goals of the National Pain Strategy. ANA looks forward to partnering with other stakeholders in disseminating tools like this.

Pain management must be truly interdisciplinary. Nurses, particularly APRNs, play a critical role in providing pain management services that yield patient-centered care and better population health that the strategy envisions. ANA appreciates the important role that RNs played in the working

groups and stands ready to identify ways that nursing organizations can play in implementation of the plan.

The lists of stakeholders and collaborators throughout the document are long ones and ANA appreciates the effort required to convene large bodies. This is particularly true with regard to accrediting and certifying bodies listed on p. 38. When convening experts to address certification, ANA encourages IPRCC to include the American Nurses Credentialing Center's (ANCC) Pain Management Nursing Board Certification (RN-BC) and the National Board of Certification and Recertification for Nurse Anesthetists (BCRNA) subspecialty certification in nonsurgical pain management.

Effective collaboration and team-based care will only occur when professionals have a full understanding and appreciation of one another's roles, and there is no better way to create that understanding and appreciation than through interdisciplinary education. The Core competencies for pain education (Appendix J) can be applied to interdisciplinary education and training and will be a crucial step toward effectively preventing and managing pain.

Nursing can lead the way in an attitudinal transformation toward pain. While it may be true that "most professional health care education programs devote little time to education and training about pain and pain care," (p. 36) that is not true of nursing education. To the contrary, pain management is a core element in nursing education. The American Association of Colleges of Nursing (AACN) publishes an "Essentials series" that outline the necessary curriculum content and expected competencies of graduates from baccalaureate, master's, and Doctor of Nursing Practice programs, as well as the clinical support needed for the full spectrum of academic nursing. The *Essentials* demonstrate that pain management has been part of nursing education and training for quite some time. Specifically, "relieving pain and suffering" is included in the definition of **patient-centered care** and pain management is suggested as a core area of the principles of basic nursing care in the Baccalaureate Essentials. Additionally, the Commission on Collegiate Nursing Education (CCNE) requires that programs must incorporate the 'Essentials' into their curricula (standard 3-b). Although there may be few classes titled/devoted to pain management, it is integrated into the curricula throughout nursing programs as a core component of patient-centered care.

The *Guiding Principles for Big Data in Nursing* should guide implementation of IT-related components of the National Pain Strategy. Information technology clearly has a large role to play in implementation of the strategy and ANA encourages the IPRCC to leverage nursing informatics experts in the promotion of standards and interoperability. In particular, nursing recommends "consistent use of research-based assessment scales and instruments that are standardized through an international consensus body," including pain scales and chronic pain screeners. "The lack of standardization makes comparison of data challenging and adds to the burden of cost for copyright permissions and/or licensing of such instruments."

The National Pain Strategy spells out many short, medium and long term strategies and deliverables and identifies key stakeholders and collaborators that must play a role in successful implementation of the strategy. ANA sees many opportunities for nursing to play a role and looks forward to opportunities to assist with the implementation of the strategy.

We appreciate the opportunity to share our views on the National Pain Strategy. If you have questions, please contact Mary Jo Assi, DNP, RN, NEA-BC, FNP- BC, Director of Nursing Practice and Work Environment at maryjo.assi@ana.org or 301-628-5021

Sincerely,

Debbie Hatmaker

Debbie D. Hatmaker, PhD, RN, FAAN
Executive Director

cc: Pamela Cipriano, PhD, RN, NEA-BC, FAAN, ANA President
Marla Weston, PhD, RN, FAAN, ANA Chief Executive Officer