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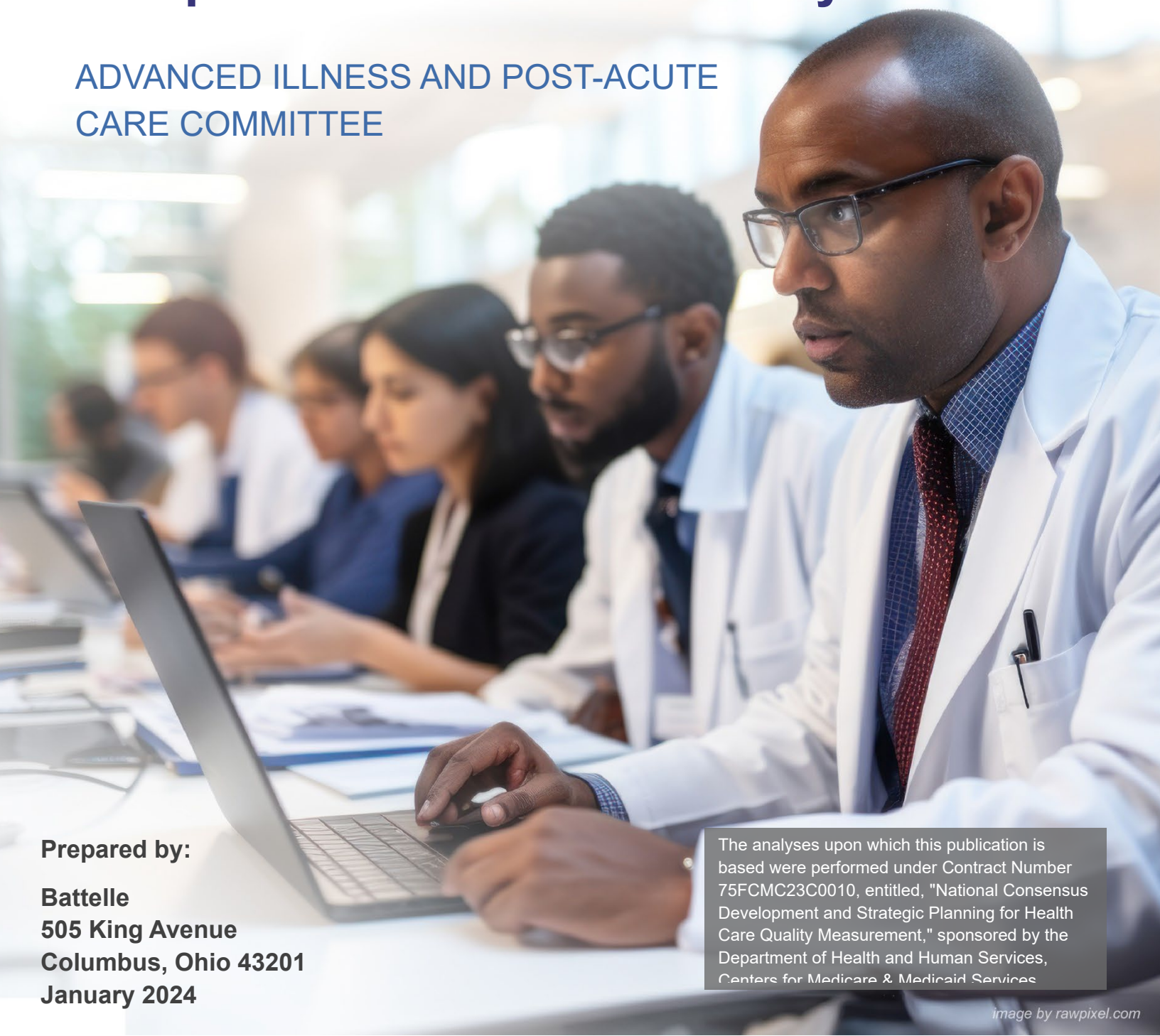
Fall 2023 Endorsement and Maintenance (E&M) Committee Independent Review Summary

ADVANCED ILLNESS AND POST-ACUTE CARE COMMITTEE



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Summary of Committee Independent Reviews

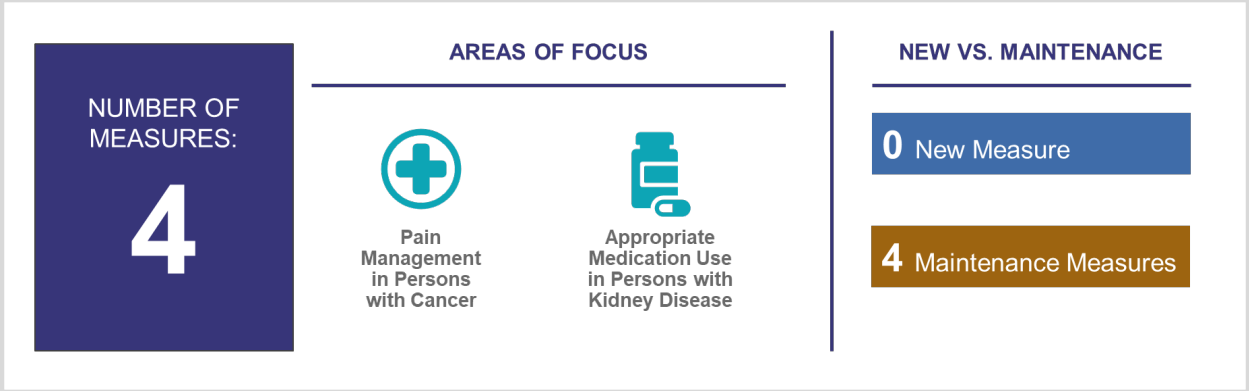
Independent E&M Committee Member Reviews Overview

At least three (3) weeks prior to an E&M committee endorsement meeting, the Recommendations Group and the Advisory Group of each E&M committee receive the full measure submission details for each measure up for review, including all attachments, the Partnership for Quality Measurement (PQM) Measure Evaluation Rubric, the public comments received for the measure(s) under review, and the E&M team preliminary assessments.

Members of both groups were asked to review each measure, independently, against the PQM Measure Evaluation Rubric. Committee members assigned a rating of "Met," "Not Met but Addressable," or "Not Met" for each domain of the PQM Measure Evaluation Rubric. In addition, committee members provided associated rationale for each domain rating, which is based on the rating criteria listed for each domain. Battelle staff aggregated and summarized the results and distributed them back to the committee, and to the respective measure developers and/or stewards, for review within one (1) week of the endorsement meeting.

These independent committee member ratings are compiled and used by Battelle facilitators and committee co-chairs to guide committee discussions.

Figure 1. Fall 2023 Measures for Committee Review



For the Fall 2023 cycle, the Advanced Illness and Post-Acute Care committee received four (4) measures undergoing maintenance endorsement review (Figure 1). The measures focused on pain management in persons with cancer and appropriate medication use in persons with kidney disease.

Measure-Specific Summaries

The following brief summaries include themes and considerations gathered from the committee's independent reviews for each of the five domains of the PQM Measure Evaluation Rubric. Themes were assessed and categorized with respect to the strengths and limitations of the measure(s) under endorsement review. Corresponding to the themes are the number of committee reviews received and stratified by the ratings of "Met," "Not Met," and "Not Met, but Adressable."

CBE #1662 – Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy

Number of Committee Reviews: 15

Importance (n=15)	Strengths	Limitations
No Consensus 67% Met 33% Not Met, but Addressable 0% Not Met	• **CKD as a Public Health Problem:** CKD affects 37 million Americans. Efforts to increase ACEi/ARB use have reduced kidney failure incidents. • **ACE Inhibitors and ARBs in CKD:** ACEi and ARBs are key for anti-hypertension in CKD and slowing disease progression. • **Performance Gap:** There is a clear performance gap in the usage of ACEi and ARB among patients with CKD. Data show a gap in ACEi/ARB prescription among physicians and CKD patients. • **Quality Measure is Useful:** Expressed need for quality measures to improve the use of ACE inhibitors and ARBs in patients with CKD. The measure is crucial for high-quality nephrology care and is supported by various organizations.	• **Current Data:** Data are outdated. More recent data are needed, expected from MIPS 2022-2023. • **Measure Limitations:** Identified limitations, including lack of empirical demonstration of outcome association and concerns about accounting for hyperkalemia after RAAS initiation. Request for clarification and mitigation approaches for patients placed on very low doses of RAS blockade rather than having the dose properly titrated. • **Proteinuria and Treatment:** The amount of proteinuria that necessitates treatment has different thresholds, depending on the source: (> 300 mg/g on UACR or UPCR for this metric; other sources suggest UACR > 300 mg/g or UPCR > 500 mg/g others might say > 1000 mg/g).

Feasibility (n=15)	Strengths	Limitations
No Consensus 20% Met 73% Not Met, but Addressable 7% Not Met	• **Measure Specifications:** There are clearly defined values and definitions for the numerator, denominator, exclusion, and exceptions.	• **Measure Specifications and ICD-10 Codes:** Request for clarification on identifying ICD-10 codes for CKD, the degree of proteinuria, erroneous ICD-10 code entry, and if the patient is being prescribed an ACE/ARB. • **Data Collection:** A significant portion of the measure definition requires manual chart review to determine measure outcome scores. Chart review is very difficult. • **Exclusion Criteria:** Some committee members mention the need for a detailed, near-universal method for identifying denominator exclusions. Measure developers did not address the potential burden of identifying criteria for exclusion from the denominator based on medical contraindications or patient choice. It also raises questions about specific ICD-10 codes (like N18.6) and their role as automatic exclusions.

Scientific Acceptability (n=15)	Strengths	Limitations
Consensus 13% Met 87% Not Met, but Addressable	• **Measure Specifications:** The measure is well-defined and specified. • **Reliability Testing:** Significant gap in performance, which may suggest high entity-level reliability. The measure submission indicates a high level of reliability.	• **Outdated Data:** The comments repeatedly mention that the data used to support the measure's validity and reliability are outdated, specifically from 2007 and 2008. It suggests that the measure should have been retested given changes in EHRs and medical practice.

Scientific Acceptability (n=15)	Strengths	Limitations
0% Not Met	• **Face Validity Testing**: The developer provided adequate evidence of face validity. • **Support for the Measure:** The measure is supported by various medical entities.	• **Entity-Level Reliability and Validity:** Entity-level reliability and validity have not been assessed. Concerns are raised about the potential for low entity-level reliability, especially for entities with low denominator size, if the gap in performance has narrowed. While face validity is clearly strong, there should be more empirical testing connecting the measure to outcomes. • **Entity-Level Testing:** Comments discuss the lack of entity-level reliability testing and the potential impact of this on the measure. • **Sample Size:** Committee members mention the small sample size used in the data and suggest that this is a limitation of the measure. It also mentions the need for a larger sample size for enrollment.

Equity (n=15)	Strengths	Limitations
No Consensus 13% Met 67% Not met but Addressable	• **Chronic Kidney Disease (CKD) and ACEi/ARB Use**: Committee members mention a gap in ACEi/ARB use among CKD patients, with 40% not using it. It also discusses efforts to increase ACEi/ARB use in certain populations. • **Disparities in Health Outcomes:** Comments repeatedly mention disparities in health outcomes, particularly in relation to race and gender. Comments also mention	• **Measure Performance and Current Data:** The comments discuss the need for current performance data to explore possible disparities in the measure. Comments mention that data on its performance have not yet been released by CMS and suggest that new performance data could be used to explore possible disparities.

Equity (n=15)	Strengths	Limitations
20% Not Met	disparities in hypertension control among persons with early CKD.	• Consider evidence linking social risk factors directly to the use of ACEi/ARB and showing data in the current dataset. • **Measure Impact and Outcomes:** The measure proposal indicates an opportunity to impact improved outcomes for various populations. However, given that this measure is a process measure and does not address outcomes, it is unclear as to whether this measure will truly impact patient care outcomes.

Use and Usability (n=15)	Strengths	Limitations
Consensus 0% Met 93% Not met, but Addressable 7% Not Met	• **Measure Currently In Use:** Measure currently in use in MIPS (eligible entities can receive performance-based incentives).	• **Need for Current Performance Data:** There's a need for more current performance data. The measure developer did not provide evidence of how this maintenance measure has been used to improve the quality of care for patients with CKD and did not address how it sought/responded to feedback from end users. • **Measure Evaluation and Usefulness:** Need for more detail in evaluating RAAS treatments and the importance of follow-up measures. There is a lack of direction in the measure, rendering it marginally useful to practitioners. • **Patient Education and Understanding:** Patients, especially in the early stages of CKD, are not well-educated. They will tend to follow the regime of their

Use and Usability (n=15)	Strengths	Limitations
		nephrologist. If there was a way to certify that urea, liver panel, potassium levels, and renal panel labs were checked, it would be easier to sign on for this measure. Without evidence of follow-up lab work to monitor the start of a RAAS protocol, CMS will not have a clear picture of its usefulness.

CBE #0383 – Oncology: Medical and Radiation - Plan of Care for Pain

Number of Committee Reviews: 15

Importance (n=15)	Strengths	Limitations
No Consensus 60% Met 33% Not Met, but Addressable 7% Not Met	• **Incidence of Cancer:** Comments mention the incidence rate of over 1.9 million cancer cases in 2023 and emphasizes the importance of the measure given the incidence of cancer. • **Pain Management in Cancer Patients:** Comments discuss the importance of pain management in cancer patients, the challenges faced due to the subjective nature of pain, and the impact of the opioid crisis on the reduction of valid medications for cancer patients. Need for a documented plan of care to address pain in cancer patients undergoing chemotherapy or radiation. • **Performance Rates in Pain Management:** Comments note a decline in performance rates from the MIPS-quality program data reflecting calendar years 2019-2021. Comments also mention high performance rates for practices and individual clinicians asking about pain levels, despite pain being a persistent, unmanaged issue for a large percentage of patients with cancer.	• **Quality Measures for Pain Management:** Need for more relevant quality measures to assess both pain intensity and the plan of care for pain, or a patient-reported outcome measure indicating pain improvement within a certain time period of follow up. Developers could consider expanding this measure to include other sub-groups of oncology patients as additional populations in the reported rate of this measure. • **Pain Management Plan:** Lack of clarity on whether having any plan, even if it's medically wrong, is better than not having a plan. • It's not clear that having any plan in place to treat the patient's pain, even if it is medically the wrong plan, is any better than not having a plan. • Instead of two process measures (0383 and 0384) combine into one measure; pain assessed and on the plan of care.

Feasibility (n=15)	Strengths	Limitations
No Consensus	• **Data and Measure Implementation:** All measure data elements can be documented in discrete fields within most EHRs. Easy adoption of the measure by numerous	• **Implementation and Effectiveness of Measures:** Measure developers have not updated measure

Feasibility (n=15)	Strengths	Limitations
67% Met 20% Not Met, but Addressable 13% Not Met	healthcare practices, as evidenced by the considerable number of practices reporting this measure to the Centers for Medicare and Medicaid Services (CMS) via the Merit-based Incentive Payment System (MIPS) program. • **Feedback:** Comments note that feedback from EHRs, cancer registries, and oncology practices provides compelling evidence that the measure is easy to implement.	specifications for the numerator to reflect the stated NCCN clinical practice guideline recommendations. • The measure lacks enough rigor to evaluate whether the pain plans represent an important step in treatment. • Discussion needed on whether and how data can be collected to make this measure more meaningful.

Scientific Acceptability (n=15)	Strengths	Limitations
No Consensus 67% Met 27% Not met, but Addressable 7% Not Met	• **Reliability and Validity of the Measure:** Comments note reliability scores ranging from 0.804 to 1.000 across all years analyzed at individual clinician and practice levels. • 100% of clinicians and practices had measure scores with reliabilities of 0.70 or higher, a commonly accepted reliability threshold. • No concerns with validity testing, noting that the measure has sufficient validity. • **Measure Definition and Specification:** Comments note the measure as well-defined and precisely	• **Interpretation**: Some comments express a lack of understanding about how the numerator is determined to be met. Measure developers do not address how numerator elements coded to reflect a documented plan of care for pain were tested for reliability. A “plan of care” can be carried over from visit to visit almost automatically. • **Additional Validity Testing:** Given the length of time this measure has been in use and the number of practices choosing to report it, are other measures of concurrent and construct validity available?

Scientific Acceptability (n=15)	Strengths	Limitations
	specified. All data elements for both numerator and denominator exist in structured fields. • **Validity Testing and Results: A**ll data elements for both the numerator and denominator were tested for validity. The Kappa coefficients for both the denominator and numerator data elements indicate high accuracy.	

Equity (n=15)	Strengths	Limitations
No Consensus 7% Met 33% Not met, but Addressable 60% Not Met	• **Recognition of Disparities:** The developer cites disparities in opioid access and dosage among different racial groups. General information about disparities is provided in the importance section. • **Data Collection Opportunities:** Opportunities exist for cross-referencing additional patient demographics and characteristics in the electronic medical record with pain management care planning outcomes to identify areas of equity opportunity.	• **Lack of Information/Data:** Equity was not addressed at this time, but not required. • The lack of demographics in the MIPS data and the masking of demographics in the McKesson data means inequities are not recognized or addressed. • CMS did not capture nor provide any patient-level socio-demographic variables and therefore no patient demographic data is available. • Measure developers indicated that differences could exist and that care settings are encouraged to track additional data that could reflect differences in health equity but these have not been included in measure specifications and analyses according to those data were not reported.

Use and Usability (n=15)	Strengths	Limitations
No Consensus 20% Met 73% Not met, but Addressable 7% Not Met	• **Use in Multiple Programs:** The measure is already in use in the CMS Merit-based Incentive Payment System (MIPS). • **Data/Outcomes:** Data/outcomes are actionable and address effective pain assessment as well as effective pain management care planning. • **Feedback Mechanisms:** Providers can send feedback via the CMS Helpdesk or via email to ASCO.	• **Performance Rates and Decline:** The comments discuss the decline in performance rates from MIPS-quality program data reflecting calendar years 2019-2021. Comments further note the lack of sufficient explanation for the decline and the need for more data on the decline in quality and how improvements will be implemented. • **Clarification:** Need for clearer guidance within the measure specification, particularly around the definition of pain and situations where a patient is under the care of multiple oncologists. • **Impact on Patient Care and Practices:** Some comments question the measure's impact on patients and practices, suggesting that it may not be as helpful to guide practice changes and may not do much for the patient.

CBE #0384e – Oncology: Medical and Radiation - Pain Intensity Quantified

Number of Committee Reviews: 16

Importance (n=16)	Strengths	Limitations
Consensus 75% Met 19% Not Met, but Addressable 6% Not Met	• **Pain Management in Cancer Patients:** The evidence provided emphasizes the importance of pain management in cancer patients, especially in the context of the current opiate crisis. The developer also notes the National Comprehensive Cancer Network's clinical practice guideline recommendations for comprehensive pain assessment and control. • **Performance Benchmarks and Unmanaged Pain:** The developer highlights disparities in opioid access and dosage among different racial groups. There is room for improvement in practice-level performance scores. • **Importance of Measure:** The importance of the measure is clearly outlined and supported by the literature. It discusses encounters with cancer patients receiving chemotherapy or radiation and evaluates their pain intensity.	• **Lack of Direct Patient Input:** The measure does not include direct patient input on its meaningfulness. However, a 2022 study emphasized the importance of routine pain screening, management, and follow-up. • **Need for Plan of Care for Pain:** Comments mention the inadequacy of merely asking patients about their pain intensity without requiring clinicians to develop a plan to address elevated pain. • **High Performance Rates:** There appears to be little room for improvement in clinician-level performance scores. Developers note that participants may select measures reflecting high performance rates, potentially masking a drop-in practice-level performance.

Feasibility (n=16)	Strengths	Limitations
Consensus 81% Met	• **Data Collection:** The necessary data elements required for the numerator and denominator can be found within structured fields and are recorded using commonly accepted coding standards. Data elements	• **Combining Measures:** It also discusses the possibility of combining the pain intensity and pain care plan measures to create a single, more comprehensive measure.

Feasibility (n=16)	Strengths	Limitations
19% Not Met, but Addressable 0% Not Met	can easily be collected and are easily obtained from existing entries in the electronic medical record. • **Integration with Existing Systems:** The measure's data capture can be seamlessly integrated into existing physician workflows and data collection tools without requiring any significant modifications. The feasibility of using defined areas in EMRs is achievable. • **Precedent for Implementation:** This measure is fully implemented for the Oncology Care Model and Enhancing Oncology Care Model. This sets a precedent that the pain intensity and pain care plan measures could be combined to create a single, more comprehensive measure.	• **Lack of Specificity in Documentation:** The measure specifications do not specify who documents the pain intensity or collect information regarding who documented the score in the electronic health record. Differences in scores across different physician practices or clinicians may reflect differences in which oncology team member, from a medical assistant to the oncologist, asked the patient's score.

Scientific Acceptability (n=16)	Strengths	Limitations
Consensus 88% Met 13% Not Met, but Addressable 0% Not Met	• **Reliability:** The measure has strong reliability scores. The reliability of this measure was evaluated with signal-to-noise analyses from recent data, all of which were in acceptable limits. The developers present signal-to-noise ratios, with estimated entity-level reliability exceeding conventional standards of reliability when at 0.826 and above. There is evidence of strong inter-rater reliability.	• **Lack of Specificity in Documentation:** The measure specifications do not specify who documents the pain intensity or collect information regarding who documented the score in the electronic health record. Differences in scores across different physician practices or clinicians may reflect differences in which oncology team member, from a medical assistant to the oncologist, asked the patient's score.

Scientific Acceptability (n=16)	Strengths	Limitations
	• **Validity:** The sample size is statistically valid and data element-level testing is robust. Validity was evaluated using a recent (2022) data set. Kappa statistics were used to compare manual abstraction and an automated algorithm. With very high kappa values, encounter-level validity is satisfied. The elements of the measure appear accurately measured. The measure met validity tests. Measure developers provide evidence of validity testing and strong validity. • **Importance of Measure:** The importance of the measure is clearly outlined and supported by the literature. It discusses encounters with cancer patients receiving chemotherapy or radiation and evaluates their pain intensity**.** • **Measure Specifications:** Measure is well-defined and specified.	• **Lack of Exclusions:** The measure specifications do not include any exclusions. This decreases the burden of data collection but does not allow for capture of differences in scores and/or exclusions according to patients' cognitive ability to respond to a standard pain instrument or account for patients' choice to decline to provide a rating.

Equity (n=16)	Strengths	Limitations
No Consensus 6% Met 31% Not Met, but Addressable	• **Acknowledgement of Disparities:** The developer cites disparities in opioid access and dosage among different racial groups.	• **Stratification of Measure by Race and Ethnicity:** Measure developer is encouraged to stratify the measure by race and ethnicity, noting importance of reporting per category to link it to the care plan and use of opioids appropriately. Need to address disparities and the quality-of-care gap.

Equity (n=16)	Strengths	Limitations
63% Not Met		• **Lack of Equity Information:** No subsequent data relevant to equity specifically for this measure are provided. • Drilling down on demographics may not yield much gain, as many people already understand these links. • **Suggestion for Further Investigation:** Additional literature review and/or review of existing data utilizing other patient identifying factors could be performed to further investigate opportunities for equity improvement.

Use and Usability (n=16)	Strengths	Limitations
No Consensus 44% Met 56% Not met, but Addressable 0% Not Met	• **Use of Measure in Programs:** The measure is currently in use in the Enhancing Oncology Model (EOM-4), where eligible entities can receive performance-based incentives. The measure is also in use in the CMS Merit-based Payment System (MIPS). No unexpected findings are reported. • **Quality Improvement Tools:** Other tools for Quality Improvement (QI) include Practice Insights by McKesson, a performance analytics tool used by subscribing providers, and the Patient-Centered Cancer Care Standards ASCO Certification.	• **Use of Measure in Programs:** The current use in MIPS and EOM models do not show improvement, which may be due to variables other than the effectiveness of this measure. • **Performance Gap:** Based on the review of the logic model/testing attachment, meaningful improvement in the clinician-level measure is probably limited to the bottom 4 deciles, and no improvement has been made from 2019-2021. The mean performance at the practice level falls between 2019 and 2021 (0.68 to 0.50), however, the developer does not provide a rationale for this decline.

Use and Usability (n=16)	Strengths	Limitations
	• **Performance Gap:** A performance gap remains at the practice level, where there could be meaningful improvements in at least the bottom 8 deciles. Data can be used to identify gaps in care related to pain management. • **Feedback Mechanism:** Providers can send feedback via the CMS Helpdesk or via email to ASCO.	• **Pain Assessment:** There is a desire for more clarity on how pain is being assessed and potential endorsement of a universal measurement tool (e.g., PROMIS-Pain). More guidance is needed on how this should be measured: pain or just cancer-related pain? What is the justification for the scale that is used? Users would benefit from clarification around the definition of pain.

CBE #0384 – Oncology: Medical and Radiation - Pain Intensity Quantified

Number of Committee Reviews: 13

Importance (n=13)	Strengths	Limitations
No Consensus 31% Met 69% Not Met, but Addressable 0% Not Met	• **Pain Management:** The comments emphasize the importance of routine pain screening, management, and follow-up. Assessing and managing pain has strong evidence. • **Cancer Patients:** Comments not the incident rate of over 1.9 million cancer cases in 2023 and the prevalence of pain among cancer patients during treatment. They also mention the importance of this measure for patients with a cancer diagnosis undergoing chemo or radiation each year. • **Business Case:** There is a business case supported by credible evidence depicting a link between health care processes to desired outcomes for cancer patients. The literature review provides supporting evidence of measure importance	• **Pain Assessment and Control:** Comments suggest that pain assessment should not be limited to only the scales listed but should also include assessment of pain impact on function. • Measurement of pain intensity may be necessary but not sufficient to adequate pain control. • **Performance Gap:** Comments question if the performance gap appears closed and if the existence of the measure is keeping the gap closed. It is also unclear if measure variation remains as participants are allowed to self-select measures and may select those reflecting high performance rates, which could potentially mask a drop in performance. • **Expanding the Measure Scope:** The text suggests that the measure developers could consider expanding this measure to include cancer patients receiving other treatment modalities, such as those receiving oral chemotherapy agents or “maintenance” chemotherapy once a month or less.

Feasibility (n=13)	Strengths	Limitations
Consensus 77% Met 23% Not Met, but Addressable 0% Not Met	• **Data Accessibility:** The necessary data elements required for the measure can be found within structured fields and are recorded using commonly accepted coding standards. Items needed are from existing fields. • **Integration with Workflow:** The measure can be easily incorporated into workflow and can be readily measured. The measure's data capture can be seamlessly integrated into existing physician workflows and data collection tools without requiring any significant modifications. • **Cost:** There are no fees for not-for-profit hospitals, healthcare systems, or practices to use the measure.	• **Documentation:** The measure specifications do not specify who documents the pain intensity or collects information regarding who documented the score in the electronic health record. • **Unclear Reporting Process:** It's unclear how doctors and practices are documenting pain intensity numerically and how information is being taken out of the medical record for reporting purposes. • **Specialty Application:** It's unclear if this metric applies to medical oncologists and radiation oncologists.

Scientific Acceptability (n=13)	Strengths	Limitations
Consensus 77% Met 23% Not Met, but Addressable 0% Not Met	• **Reliability:** The reliability scores are high, much above the threshold. The developers present entity-level reliability using signal-to-noise ratios, which meet or exceed 0.859. This exceeds conventional standards for reliability. Measure developers provide evidence of reliability testing and strong inter-rater reliability. The Kappa coefficient threshold for reliability is met. • **Validity:** The developer tested the validity of the data elements (both numerator and denominator) using a	• **Entity-level Validity is Not Provided:** As a maintenance measure that has been in existence for several years, the submission should also include measures of concurrent validity. How correlated is this measure to other measures related to patient quality for pain or cancer? Are the correlations reasonable? • **Decline of Events:** Although the aggregated numbers do not show a statistically different picture, there is a concern about the decline in events and a request for the

Scientific Acceptability (n=13)	Strengths	Limitations
	random sample of 500 patient encounters across 10 test sites. The Kappa coefficient for the denominator data element was 0.96, indicating almost 100% accuracy. The Kappa coefficient for the numerator data element was 1.00, indicating 100% accuracy. The validity scores are high per Kappa coefficients. With very high kappa values, encounter-level validity is satisfied. The elements of the measure appear accurately measured. Measure developers provide evidence of validity testing and strong validity. • **Agree With the Staff Assessment:** Several comments agreed with the staff assessment and rating of Met.	developer to offer some ideas about the decline in events pulled into the data.

Equity (n=13)	Strengths	Limitations
No Consensus 8% Met 38% Not Met, but Addressable 54% Not Met	• **Standardized Pain Assessment:** The comments emphasize the importance of quantifying pain intensity using standard instruments such as a 0-10 numerical rating scale, visual analog scale, a categorical scale, or the pictorial scale. • **Recognition of Inequity:** The comments acknowledge the existence of disparities in pain treatment and access to pain treatment across ethnic groups.	• **Opportunities for Further Exploration:** Further exploration is possible by cross-referencing other patient identifying factors readily available in the electronic medical record with these measure outcomes. • **Absence of Health Equity Data in Measure Specifications:** Comments note that measure developers indicated that differences could exist and that care settings are encouraged to track additional data that could reflect differences in health equity, but these have not

Equity (n=13)	Strengths	Limitations
		been included in measure specifications and analyses according to those data were not reported.

Use and Usability (n=13)	Strengths	Limitations
No Consensus 46% Met 54% Not Met, but Addressable 0% Not Met	• **Measure Use:** The measure is in use in two federal programs. • **Improvement**: There has been a reported improvement of 3 percentage points from 2020-2021 at the clinician level.	• **Decline in Practice-Level Performance:** There is an unexplained decline in the practice-level performance scores. • **Topping Out:** The measure seems to be topping out, especially as a clinician-level measure. • **Alternative Pain Assessment Scales:** The measure may unintentionally promote the use of simple pain scales when there is growing evidence that a more comprehensive and person-centered assessment of pain is warranted. • **Justification for Continued Use:** Further justification should be provided to support the continued use of this measure in MIPS and other quality performance programs. • **Evidence of Improvement:** The evidence of improvement is muddled due to the lack of a stable cohort to compare across years.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