NATIONAL QUALITY FORUM

Moderator: Christy Skipper
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Operator: This is Conference #92639863.

Operator: Welcome, everyone. The Webcast is about to begin. Please note today's call is being recorded. Please stand by.

Christy Skipper: Good afternoon, everyone, and welcome to the Infectious Disease Q&A Call. My name is Christy Skipper, project manager. And around the table with me, I have Melissa Mariñelarena, our senior director, and our project analyst, Mauricio Menendez.

The purpose of our call today is to acquaint you with how we will do -- how we complete the preliminary analysis for each measure and what you should be looking for when reviewing your measures. On this call, we will go in depth -- go in more depth on the measure evaluation criteria. And we want to make this as interactive as possible. So, as we move along through the example measure worksheet that you see on your screen, please feel free to stop us and ask any question that you have.

So, again, what you will see on your screen is a measure worksheet score, a measure that was used in a different project. But, we think this is a pretty good example of a measure that was submitted to the project. And it shows you how NQF staff (or whatever work) through the measure and refashion the information into a format that makes it easy for you to read and walk through.

On our last call last month, I noted that there were two additional measures that would be submitted to the project, and we did receive those. So, we are now at nine measures. And the two additional measures focus on sepsis and septic shock.

I will leave it right there for now, unless there are any questions before we get started. But, if not, then we will -- I will turn it over to Melissa, and we will start walking through the measure worksheet.

Melissa Mariñelarena: Thank you, Christy.

Are there any questions before we get started?

OK. If not, hopefully, this will not take two hours of your time. But, thank you for joining us. Again, this is Melissa Mariñelarena, the senior on the project. (Anything added for septic and sepsis).

Christy Skipper: OK. I am sorry. Before we get started, I just want to remind everyone to please mute your line. And I believe you can do that by pressing star, six. Or, operator, if you can mute the lines for us so we don't hear any feedback. Thank you.

Melissa Mariñelarena: Thank you.

So, again, this shouldn't take up two hours of your time. But, if we needed two hours, that is fine because that is what we blocked on your calendar.

So, again, like Christy said, this is just to give you an idea of the preliminary analysis that you are going to receive from the staff. And this is all of the information on the measures. And you will be getting those before the workgroup calls.

So, the first sheet is what we call the Measure Information Form. This is all -- comes straight from the measure developer. So, this gives you the measure title, the steward, a description, the rationale. And, then, you get the

numerator statement, denominator, exclusions, type of measure. All this is standard. And, again, this is entered by the measure developer. And, then, you get some idea -- you get history on the measure, whether it is a maintenance measure or an electronic measure. So, that is the top of the measure.

Then, we actually get into the preliminary analysis. This is an example of an endorsed maintenance measure. So, this is not a newly-submitted measure. Again, in our project, we have five measures that are up for endorsement and four newly-submitted measures. And there is a little bit of a difference only in the emphasis on the different criteria, which we had talked about before briefly. We will talk about it here. And, then, you will see it again in the preliminary analysis the staff is writing up.

So, the first criteria that we evaluated evidence -- and this is for a process measure. And what we require for a process measure versus an outcome is different. If you scroll down -- so, for a process measure, we are looking for systematic review of the evidence specific to the measure.

Female: (Interrupt you). I am not seeing anything on the screen.

Melissa Mariñelarena: Is anybody -- is everybody else seeing everything on the screen?

Female: Yes.

Male: We see it.

Female: Yes.

Male: …the screen (is fine).

Melissa Mariñelarena: OK. Maybe, if you refresh your screen.

Female: OK. Sorry.

Melissa Mariñelarena: OK. So, we are looking for -- process measure -- again, we are looking for a systematic review of the evidence that is specific to the measure. We are looking for the quality, quantity and consistency of the evidence. And, then, we are looking to see if the evidence was graded. And, then, we will give you a summary of what was provided. Again, if the measure is a maintenance measure, there is less emphasis on the evidence because we just asked measure developers to decrease the burden of the measure submission process. We just asked if there is no new evidence, they can just give us the -- what they had submitted before. And, then, if you look at the very bottom where you will see "Changes to evidence from the last review," they can tell us if there is new evidence or now. And if there's updates to the evidence, then they can provide that to us.

The difference with the new maintenance process, which is now not so new, is that the committee can decide whether they want to discuss the evidence and revote on the evidence. And, again, that is entirely up to the committee. We will do an evaluation based on previous evidence, updated evidence. But, we really leave it up to the committee. Often, committees will discuss it and not vote or they will discuss it again to revote. But, it is entirely up to the committee. Sometimes, it just takes one committee member to want to vote and, then, we do -- you know, the co-chairs will be leading this discussion. But, then, we do suggest that the committee -- the entire committee revote on the evidence.

And we will put in some questions where you see questions to the committee. Some of these is a template for us, so we have some template language. Other times, there may be something that we find in a documentation that maybe we insert in there to get the committee thinking about.

And, then, in the green section is where we give you the guidance from the algorithm. And we try to be as specific as possible (and since the beginning have been) more specific about this. And we guide you through the evidence or we guide you through the algorithm. And this is an algorithm for the process measure. And we, again, tell you, you know, which box to go through. Our job is to follow our algorithms.

And, then, we give you the preliminary rating. Our process is that if staff rates any criteria either "low" or "insufficient," we will provide you with a rationale as to why we did it. And we are very specific about why we did it. And if -- when we rate something "insufficient," it is not a bad rating. We actually consider "low" a bad rating, not "insufficient." "Insufficient" just means that we did not have enough information in front of us in the form to be able to come up with a rating.

Often, we will ask committees to -- "You are the ones that are voting. You are the ones that are making the decision. So, based on the information in front of you, your experience, your expertise, any additional information that the developer may have when they come to the meeting or questions that you can ask them because they will be at the table, you base your decision on that." So, again, if you see an "insufficient" rating, it is not necessarily a bad thing. But, we follow our criteria and our algorithm and we base it on what is in front of us at that time.

(Woody): Melissa, this is (Woody). Could you please explain the QQC and the SR acronyms and how that refers to a diagram that we may or may not get to during this discussion?

Melissa Mariñelarena: Sure. (Marissa), if you could pull up the algorithm.

So, it is very common for a process measure to use guidelines as evidence. And what we like to see for a guideline is for the guideline to be presented. And, then, when we look for the systematic review, which is the SR, the systematic review of the body of evidence is to have a -- the systematic review may be based on a guideline or the guideline that is used as the evidence that is supporting the measure. So, it doesn't have to be all body of evidence. But, it could be the body of evidence that is supporting -- the guidelines that is supporting the measure focus. So, that is the systemic review. We'd like to see a summary of it. We don't want just a list of references because it has to be studies, not references.

So, what we do with the process measures when we refer to box one is is it a health outcome? We say no. So, we go to box three and, then, we say, you know, was a systematic review done? We say yes. So, then, when we talk about the QQC, within the systematic review, we are looking for the QQC, which is the quality, quantity and consistency of the body of evidence. That is something that we ask the measure developers to provide us. That is not something that staff goes and looks for.

And where we decide -- if the QQC is provided to us, if you look over to the right, if we go into box five, how we determine if it is high, moderate or low -- if you go down to the next page -- we actually have -- keep going down, keep going down. We actually have definitions for high, moderate and low. So, we consider quantity of the body of evidence five or more studies that consist of randomized controlled trials. Moderate would be two to four. Low would be one study. And, then, we have definitions for the quality and the consistency as well.

You may see staff write up that the QQC was provided but no details on it. So, somebody may say the -- you know, the QQC -- or there was good quality studies. And, often, I have also seen where they have done a systematic review, but within the guideline, there were no specific details about the number of studies that were used. So, we will also note that.

And if you look on -- scroll just a little bit -- to box four where it asks if a summary of the QQC of the body evidence from the systematic review was provided in the submission form -- then scroll down a little bit -- then, it says, "Answer 'No' if the specific information on QQC was not provided." So, we follow the algorithm. So, without a QQC from the systematic review, "moderate" is the highest potential rating.

And, then, we ask -- then, it asks "Does the grade for the evidence (the recommendation indicates)?" So, then we are looking at the grading of the evidence. And we will list that for you. We will put that in the -- if the guideline -- the grading of the evidence, we also ask measure developers to provide us with that information, the level of -- or the grading of the evidence

and the definition. Again, that is not something that we go looking for. That is something that is provided to us. So, without a QQC, "moderate" is the highest rating that evidence can receive. If there is no grading, we will rate it as "low."

There is an "insufficient" rating for evidence, meaning there is no QQC, there is no grading. This is rarely used where we go into "insufficient" with exceptions, meaning there may be a measure that there will never be any kind of studies, something where, you know, you would never do a study -- that something is not going to be done but the committee feels like there should be a measure for it. So, are there -- or could there be performance measures of a related outcome? If you say "No" -- "Yes," we move through the algorithm. The way this works is the evidence is rated as "insufficient" first. And, then, the committee votes with exceptions. So, it ends up being two different votes. So, you have to vote it as insufficient evidence but it is with exceptions.

So, ultimately, the committee decides. It is -- it is question 12, "Do you agree that it is OK or beneficial to hold providers accountable for performance in the absence of empirical evidence of benefits to the patient?" We don't see this too often. And, as I said, we have three outcome measures, three -- two different kinds -- two different kinds and the rest are all process measures.

Now, for outcomes measures -- let scroll back up -- we just require that measure developers provide a relationship between the measured outcome and a health care action or process. And, then, the question to the committee is, "Do you agree with this rationale that there is a relationship?" And the question is just yes or no. So, outcome measures in the evidence is not as -- is not as stringent as it is for outcome measures.

So, I am going to stop right there and see if there's any questions.

OK. So, we will move on. So, the next criteria that we look at is gaps or opportunity for improvement. And disparities is part of this. This is a must-pass criteria. This -- with maintenance measures, there is an increased emphasis on gap and variation. So, we want to see trends in data for

maintenance measures. For a new measure, we'd like to see performance data on the measure as specified. However, if there is no data on the measure specified for a new measure, then we do accept data from the literature demonstrating that there is a quality problem. So, there has to be a justification for the measure. And, sometimes, we will get both.

And we also want to see disparities data, especially -- disparities data is especially important for measures that are close to being topped out because there still may be a gap due to disparities within. It could be based on gender. It could be based on race. It could be based on different types of payers. It really depends on the measure and the different populations that it is capturing.

The definition of topped out -- it really depends. Not all measures are meant to be performing at 100 percent or at zero percent. So, that is a discussion that the committee has. This criteria -- you do vote on it for all measures. And, again, this is a must-pass criteria. So, if a measure -- so, evidence and performance gap together is the one criteria. If it fails either one of these, we do not continue voting. The measure does not pass. There is no algorithm for this. It is just a rating that we give you. And, again, we will use our judgment. We -- and we will give you our preliminary analysis and our ratings. You do not have to agree with us. It is just a place for you to start.

And one thing I don't think I said is we will put in hyperlinks into where we get the information. This will take you to the rest of the submission form that the measure developer provided. And this is just what we have taken and summarized. And it is to make -- we try to condense the information. But, we still encourage you to read all of the submission form because all of that information is important. But, we try to take the most important information, match it up to what is specifically in our criteria and put it in one size for you. These forms are often -- they could be 50, 60, 70, 80 pages long. And because you are volunteers, we try to make it as concise as possible. But, we do encourage you to read through the entire submission form.

So, I am going to stop and see if there's any questions about gap.

OK. We move on to scientific acceptability. Excuse me. This is another must-pass criteria. The first thing that we look at is the specification like it says up here on the form there is no change in the emphasis, whether it is a maintenance or it is a brand-new measure. And here, we will line up -- we just explain all of the specifications. We will give you the data source. And, then, there is a list of questions. We will give you -- we will describe the numerator, the denominator, any exclusions, everything about the specifications, the measure logic. If it is an e-measure, there is actually a technical review that our e-measure team does. And it is -- on the bottom, you do have three e-measures that you will reviewing. And, then, we just ask some question. It's a pretty simple part here.

Then, we get into reliability testing. And, again, for maintenance measures, there is less of an emphasis on the testing data. If the testing was sufficient in the past, measure developers do not have to retest the measure. So, they can either give us the testing that they did or they can choose to update it. They can do new testing. It really depends. We have seen a whole lot of different scenarios. What we do is summarize the previous testing. And if they did new testing, we will describe the updates to the testing and, then, we start talking about -- if there is new testing, we will summarize the methods of the reliability testing and the results and we talk about whether there was measure score level testing or data element testing here.

And just like you see here, the hyperlinks will hyperlink you back to the testing form so that you could get all of the details here. But, we like to give you -- if they did measure score testing, we will take you back to the reliability scores for the measure score, whatever it is, so that you can go back and see the full details. Usually, when we describe it, we will describe the data set that they did the testing on, the type of testing like up here where it says the signal to noise and, then, get down into the results. Again, we try to make it as concise as possible for you so that you can see the results. And, then, we talk about whether it meets NQF criteria; if it doesn't, why it doesn't. And, then, there will be some questions again. Some questions may be just standard template language that we use. Others may be more specific.

And here, we will talk you through the algorithm. And if you want a screenshot -- the algorithm -- I will show you what it looks like for reliability. So, here is the algorithm for reliability. So, the first thing that we are considering is we take a look at the specifications. And are they precise and unambiguous? We say yes. We move on to box two. Was empirical reliability testing conducted? If we say yes, we move on to box four. Then, we are looking to see if the -- if reliability testing was conducted at the measure score level. If it was, then we are moving on to box five.

So, then, we are looking to see what kind of testing was done. Most often, we see signal to noise. So, that was to see did they provide signal to noise to determine the difference between one provider and another. Occasionally, we see random -- the random split-half correlation. And, sometimes -- those are probably the two more common measure score level testing that we get. Based on the results of the testing, then we decide if it was high, moderate and low and, then, we will give the rating there.

We do get asked a lot if we have a cutoff point. We do point on the language that a reliability score of 0.07 is considered acceptable. We don't have a standard at NQF. It really depends on different sources on what you consider a standard and acceptable reliability score. Some process measures tend to have higher reliability scores than outcome measures, and different things like samples can impact it. Again, this is a conversation that we encourage the committee to have. If we see something in the testing, we will call it out and then, again, have the committee have that discussion.

If the -- if measure score testing was not performed but they did patient-level data element testing or (inter-rater) reliability testing, it drops down to this part of the algorithm. And we will go through this. In box nine, we do require -- if (inter-rater) reliability or data element testing was done, we do require that all of the critical data elements were tested, and we require -- and if they only assessed percent agreement, we rate it as "insufficient" because we want more than -- again, we want more than percent agreement. If we got like an overall -- an overall reliability score to the data element, that is also not

acceptable. So, we will rate it as "insufficient." It doesn't mean that it is not right or, again, we will -- a rating of "low" would be worse. We ask the committee to use your expertise, your experience with the measure if it is a measure that has been in use. And you determine if, in fact, based on the information there and your expertise and experience with the measure, is this measure reliable?

If -- scroll up -- this algorithm up on box three -- if validity testing at the patient level was done, it actually takes us over to the validity algorithm. If patient-level validity testing was done, then patient-level reliability is not required. And that is probably really confusing. But, if it -- if it occurs in (DPA), we do -- we describe it and, then, hyperlink it to the different sections. So, it is not something that you need to figure out. We figure it out for you.

If you can go back to the PA. Go back up. Yes. So, that is where we will -- again, we will go through the algorithm. We will be as specific as possible. If we something low or insufficient, we will provide a rationale, and the committee can agree or disagree and have that discussion at the meeting.

I am going to stop at reliability and see if there's any questions.

OK. We move on to validity. The first question we ask -- we ask, "Are the specifications consistent with the evidence?" It is either yes, a somewhat or a no. Once you take that into consideration, we look at the validity testing and this is the same process. If they had previous testing, we will summarize it here, describe any updates to their validity testing. If you scroll down -- and, then, we start talking about the testing, whether it was updated testing or the previous testing. In here, we look for the measure testing, data element testing, or did they do both?

For face validity testing, "moderate" is the highest rating that they can receive. And for face validity, we have a very specific definition of face validity. If what is provided to us does not meet what we define as face validity, we will provide that in the -- in the preliminary analysis. Again, it doesn't mean our

criteria or our definition. The committee can discuss and decide if they agree that the measure has face validity based on what is provided to you.

And, again -- so, this is the same process as reliability. We will provide some questions. Within reliability -- scroll down -- we look at threats to validity, which include exclusions. We want an analysis -- a statistical analysis of exclusions if the measure has exclusions in the specifications. And we are looking to see if the exclusions have the potential to bias the measure.

Scroll down. We want meaningful differences. Can the measure -- are there statistically significant differences within the measure. In this, we want -- we don't want just the data that was provided in the performance or in the gap. We want a little bit more detailed information here. For (2B6), the comparability of data sources, I have not seen a measure that have this yet. This is where they have two different sets of specifications. I haven't seen a measure like that. I am not aware of one. For missing data -- again, this is a statistical analysis that we want of the missing data. So, you know, what happened and does this bias the measure results as well? Yes. So, those are all of the threats to validity and, then, we will talk you through the measure.

In here, you can see in the algorithm -- the first things, like I said, we consider -- are the specifications consistent with the evidence? And the first thing we address are the potential threats to validity.

If we go to the algorithm -- so, box two. Sometimes, measures are rated as "insufficient" if -- it says all potential threats to validity that are relevant to the measure empirically assessed. Sometimes, they are not all empirically assessed. But, if they were at least address in some way, some measures will be rated as "insufficient" if they didn't even address any of the threats to validity or will say something about it. And, then, we will go through the rest of the -- of the algorithm. But, we ask the committee to have that discussion. You know, if there was no analysis done of exclusions and the measure has a lot of exclusions, what is the potential impact on the measure with a lot of exclusions and there is no testing on it? You know, is that sufficient without any testing? That is the conversation for you to have.

And, so, this will take you -- so, once we get through the potential or address all the potential threats to validity, then we look to see if empirical validity testing was done. If it wasn't and it was just face validity, we go to the right to box four.

Again, it is very specific about what we ask. We want to know if it was systematically assessed by recognized experts to determine agreement on whether the computed performance measure score from the measure as specified can be used to distinguished good and poor quality. And if that is a yes, then we move on to box five.

And, again, this is the highest rating a measure can receive on validity with face validity as "moderate." If the face validity focused on -- like it says on box four, if it focuses on data element accuracy, availability, feasibility or something else, then we rate it as "insufficient." And, then, we ask the committee to have a discussion about whether you consider what was provided face validity.

If you scroll down, we also -- if we have validity testing of the measure score, we have examples of what that looks like. We don't get that as often. And, then, the bottom part of the algorithm takes us into the patient-level data element. Again, if you do -- if we get data element validity testing, we want data element validity testing of all the critical data elements. We define that at a minimum of numerator, denominator and the exclusions. And we want more than just percent agreement. If we do not receive more than just percent agreement of all the critical data elements, we rate it as "insufficient" and have the committee have that discussion.

We can go back to -- thank you. OK. I am going to stop there and see if there's any questions on validity.

OK. If a measure does not pass reliability and/or validity, which are both must-pass criteria, the measure fails and we stop the discussion there.

I haven't talked about another category, which is what we call consensus not reached or the gray zone, which we end up -- what is that -- between 40 and 60 percent within -- and that -- again, that means consensus not reached. We continue the discussion and, at our post-comment call, the committee will have to revote and, at that time, the measure will either pass or fail.

Our next criteria is feasibility. This is not a must-pass criteria. But, for measures that have been in use and have come back to us for maintenance, there is no change in emphasis. This is -- we look at what the data source is. Is it -- are the data elements available in EHR? How much of a burden is it to collect the data, to report the data? Is there a cost? If it is a registry, is there a cost to participate in the registry? Those kinds of things is feasibility.

If it is an e-measure, even a legacy measure which the legacy measure that you will see -- testing is not required and you will not see reliability or validity testing. They did test in a synthetic testing environment. And that is testing the measure logic. And that is what we accept for what we call legacy measures. But, you will see a feasibility scorecard. And that is what we require for all e-measures. And, then, we will also provide -- we will provide an analysis of that as well. And that is looking to see if the data elements that are required for the measure -- how available are they? Did they have any trouble with them? How available are they now? If they are not available now, you know, they may say, well, they were available in certain EHRs but not in others. We will take a deep dive into that and provide that language for you. There is no algorithm for this. We just provide a rating and, then, ask you to discuss this.

And, then, we move on to usability and use. With measures that have been in use, there is an increased emphasis. We want to know the current use. Are they publicly reported? Are they in an accountability program or is there a plan? And, then, we list out the details of this. You know, if they have been endorsed for a while and they haven't been used, we want you to have that discussion. And, again, you know, if they haven't been used, what is -- what is the impact of a measure?

Scroll down. And there is a few additional sections. We talk about unexpected findings, potential harms. This is all reported -- that we information that we (get by this) developer -- we do try to find any other information that we may have or that we are aware of. We talk about feedback. If there is a measure that has been through our other process, the measures application partnership, we will provide that information here. And for those of you that aren't familiar with it, we will also give you more information. And that is the group that provides recommendations to HHS or, more specifically, CMS about what measures to put into their payment programs. And there were three of the measures -- right? Three of the measures were reviewed by MAP this year. So, we will include in here what the MAP group had to say about the measures as we are trying to integrate the two processes a little bit more. So, we will let you know about that and we will talk about it more at the meeting as well. And, then, we will put some questions here for you.

Are there any questions?

OK. Does this have the Endorsement Plus? It probably doesn't, does it?

Female: (I don't think so).

Melissa Mariñelarena: OK. You will see one section about the new Endorsement Plus. And I don't think it is in this form. That will have some questions about whether a measure qualifies. And it is very specific about whether a measure qualifies for endorsement -- the new Endorsement Plus or not. Those have a little bit. The criteria is a little more stringent. They have to have measure score level testing. Has the measure been vetted? There is definitions for all of that. But, it is not in here.

I will mention related and competing measures. Whatever information is here is what is provided to us by the measure developer. We also do our own analysis using this information and looking at our entire portfolio and any new measures that have come in since this was completed. We will ask the committee to discuss related and competing measures after the measures have

all been voted. We ask -- because we don't -- we don't ask you to vote based on whether a measure is related to another measure or is competing. Each measure is voted on its own merit. Once those decisions are made, then we discuss related and competing. Because we have a one-day meeting, if we have time, we will do it then. If not, we will do it -- we do have a post-meeting call. We can do it then. The staff will put all the information together and, then, ask you to have that discussion. But, we will talk about that later. We don't have to do that now.

OK. I am going to stop. Are there any questions?

Christy Skipper: OK. Thank you, Melissa.

I am just going to make a few announcements. And if you all do have questions, please feel free to ask them.

I just to point out two things on this measure worksheet. At the bottom of your screen, you will see that bluish-colored box for pre-meeting, public and member comments. So, on Thursday, we move measures submitted to the project for a 14-day pre-meeting public and member commenting period, and anyone from the public can give their initial impressions on the measure. We take all of the comments received and we (post) their comments -- those comments within this blue box on the worksheet.

If you scroll up a bit, there is also a pink box for committee free evaluation comments. That pink box is -- collects comments from you as committee members of every single criteria for each measure. And over the coming week or two, we will be sending out a link for you all to begin to enter your initial thoughts about each measure, whether it is reliable, valid, what do you think about the evidence and gap and, then, also usability and feasibility. But, I just want to let you know that we all are working on finalizing the PAs for all nine measures submitted to the project. So, what we just walked through today -- you will have one of this for every single measure submitted to the project. And we will make assignments so that every committee member

reviews at least one of these -- one of the measures in the project and we make those assignments based on your expertise.

You will also receive -- so, in addition to receiving notification of which measures you will be assigned to discuss, You will also be assigned to a workgroup call. We have our first workgroup call at the end of the month on February 28 from 11 to 1 p.m. Eastern Time.

So, on that first call, we will more than likely discuss our HIV-AIDS measures. And if you are assigned one of those measures, you will be expected to dial in and sort of discuss your preliminary thoughts about the measure and also ask questions of the developer if there is something that you don't understand or even ask question of us as NQF staff.

Our second workgroup call is the next day, March 1, from, I believe, 12 to 2 p.m. Don't quote me on that. But, we will send out the calendar invitation. On that call, we will be discussing the sepsis measures. And, again, if you are on that call, we ask that you please dial in and participate. And even if you weren't assigned -- if you aren't assigned a sepsis measure or if you are not assigned an HIV-AIDS measure, please feel free to participate in either -- or participate in both of the workgroup calls just to hear, you know, what your colleagues are saying about the measures and just hearing some of their initial questions.

I also want to give you a heads-up that our in-person meeting is on March 14. You should be receiving information from our meetings team how to reserve your hotel and travel to our meeting in Washington, D.C. You should be receiving something in the next week or two.

And I see a question here in the chat box -- chat box. When will the measures be assigned? We will be making those assignments in over the next week. So, you should -- you will hear something from us this time -- by this time next week.

I just also want to point everything that we presented today, the algorithm and more detail about the measure evaluation criteria -- all of that is posted on the committee SharePoint page. So, if you navigate to our SharePoint page, there is a document called "Measure Evaluation Criteria Guidance." Please feel free to take a look and start getting familiar with that. And then, also, I want to point out the CDP Committee Guidebook just answers questions about the CDP process and expectations at the in-person meeting and on our workgroup calls.

One final thing that I want to point out is for each of the measures, there will be a lead -- a pair of lead discussions that will be asked to kick off the discussion of the measure at the in-person meeting. So, the workgroup calls give you all a chance to talk to one another and get some of your questions answered and help prepare you to how you will present the measure at the in-person meeting. And we also have a measure discussion script that we will provide to each of you for your review. And we will provide that to you in advance of the workgroup call. You can also ask us questions about that as well.

I see one more question in the chat box. When will the measures be posted? We will begin posting our HIV-AIDS measure, again, by this time next week. We are still doing some work on the sepsis outcome measure. So, we will have to sort of post those a few days later. But, we will send out notice once all the measures are posted to our project page.

And I will also mention the pre-evaluation survey. So, for each measure that you all are assigned, you will be asked to just answer a couple of questions about the measure. And even if you weren't assigned a particular measure and you would like to provide comments on that pre-evaluation survey, we ask that you please do that. And you will be receiving information about all of the things that I mentioned -- so, what measures you are assigned, which workgroup call you will be assigned to and, also, instructions on how to access the committee -- the committee evaluation survey. We will send notice on all three of those things over the coming days.

One final reminder. You should have received a message to submit your disclosures of interest. Please submit those as soon as possible even if you have nothing to disclose about the measure, you didn't participate in the development of it, please just submit a blank form and make sure that you send it to us. You will not be able to participate in our workgroup call if we do not have documentation of your disclosure of interest.

And I believe those are all the announcements I wanted to share.

Are there any other questions that came up? Or if there is anything that I missed, team, feel free to jump in.

Melissa Mariñelarena: Of if you don't have enough to do yet.

(Woody) or (Adam), as co-chairs, is there anything that you would like to add or any questions that you have?

Male: No. Thank you for the review. I think we are ready to go.

Melissa Mariñelarena: OK. And after you receive the preliminary analysis of your assigned measures and if you have -- if anybody has any questions at all, please reach out to us. We are here to answer questions, to help you. This is a lot of information in a really short amount of time, and it takes a long time to digest it. And we understand that you are volunteers and we appreciate your time.

So, please do not hesitate to reach out to us if you have any questions or need any help with any of these information.

Male: Very good. Thank you.

Melissa Mariñelarena: Thank you, everybody. You have an hour and nine minutes back.

Male: Very good.

Melissa Mariñelarena: And we will talk to you soon. Thank you, all, very much.

Christy Skipper: Yes. And we will send -- and we will send you a note if we haven't received your disclosure of interest. Thank you.

Female: Goodbye. Thank you.

Female: All right. Goodbye.

Male: Goodbye. Thank you.

Male: Thanks.

END