# Ambulatory Surgical Center Quality Reporting Program

## Support Contractor

## CY 2016 OPPS/ASC Final Rule: Ambulatory Surgical Center Quality Reporting (ASCQR) Program

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**Matt McDonough**: We're going to do things a little bit differently today. Before we turn things over to our first presenter, we do want to start things off with a polling question. The question is this: have you read the final rule yet? This is a yes or no question. We appreciate all 460 responses to this question.

It's about 25 percent of you who have read the final rule yet, and kudos to you for taking the time to do that, and the remaining 75 – just a hair over 75 percent have not yet read that rule. We do appreciate all of you who took the time to provide feedback to us.

We're going to go ahead and turn things over to our first presenter today to get our event started.

**Tamara Heron:** Hello, and welcome to the Ambulatory Surgical Center Quality Reporting Program webinar. Thank you for joining us today. My name is Tamara Heron, and I'm a project coordinator for the ASCQR Program.

If you have not yet downloaded today's handouts, you can get them from our website at qualityreportingcenter.com. Go to the events banner on the

right side of the page, click on today's event, and there will be a link that will allow you to access and print the handouts for today's webinar.

For today's webinar, we are live streaming in lieu of using only phone lines. However, phone lines are available should you need them.

Before we begin today's program, I would like to highlight some important announcements. On December 16, 2015, CMS' Elizabeth Bainger will present a webinar on measure development and the importance of public involvement. On January 27th of 2016, there will be a webinar on the ASC Specifications Manual.

Our learning objectives for this program are listed here on this slide. This program is being recorded.

Now, let me introduce our speaker. I am pleased to introduce today's speaker, Dr. Anita Bhatia. Dr. Bhatia is the program lead for the ASCQR Program and has been with the program since its inception in 2007. She received her PhD from the University of Massachusetts Amherst and her master's in public health from John Hopkins University.

Dr. Bhatia plays a crucial role in the development of the OPPS proposed and final rulings. Her contributions to the rulings are essential to the continuing success of the ASCQR Program. We are fortunate to have Dr. Bhatia's commitment to this program and ultimately to patient care outcomes. I will now turn the program over to Dr. Bhatia.

Anita, the floor is yours.

**Anita Bhatia:** Thank you, Tamara.

Hello, everyone. As Tamara introduced, we are going to talk about the final rule for calendar year 2016 payment, and we are going to focus on

the ASC Quality Reporting Program. Here on slide nine, we note that we are going to start with locating the rule.

We outlined the ASC Quality Reporting Program rule history. These are all the payment rules, CMS payment rules, that the program has been discussed, or there have been proposals that have come through and been finalized. We began in calendar year 2009 where we began discussing the program. We moved through these years.

We know that we do have one year, which is fiscal year 2013, where there were requirements that were finalized in the Inpatient Prospective Payment System rule. But other than that, all of our proposals and discussions have been in the Outpatient Prospective Payment System rule. We are ending with our current rule of calendar year 2016.

Before I go forward, I do want to note that the *Federal Register* reference is here, and we are going to be focusing on 80 FR for *Federal Register* and beginning with the page number 70526. We are going to talk about finding our rule in the wonderful *Federal Register* pages that are on the Internet.

This slide shows the home page for the *Federal Register*. On this screenshot, you can see that we've copied and pasted the volume number, again, which is 80 FR for *Federal Register* and the beginning page number for this issue, which is 70526. That is the first page of the ASC portion.

Next, we would click the magnifying glass in the search box to start the search. As you can see, it takes you directly to the final rule of interest. Here is highlighted a box that starts with the words "jump directly to."

Before we discuss this feature, I would like you to look at the line above that box. The page numbers are there. That's telling you that the final rule

begins on page 70297 and ends on page 70607. I mean, that is a very long document.

The ASC Quality Reporting Program portion is just one small part of this very large final rule. There are finalized proposals and sections for many other programs here at the Centers for Medicare & Medicaid Services. Let's look at the highlighted box that reads "jump directly to page 70526." When you click on the page number, it will take you directly to that page.

Here on slide 13, we can continue navigating the *Federal Register*. If you scroll down a bit, you will see the start of the ASC Program portion. It starts with the Roman numeral XIV. Now, this view of the final rule is one long column of text.

Some people like to view the rule this way, but many others prefer to view the rule on – as it appears in the publication, and that's displayed in a PDF format in the *Federal Register*. So, let's go back to the previous slide.

This time, I've highlighted the PDF link, and when you click on this, it takes you to the PDF version of volume 80 of the *Federal Register*. You can use your find feature to look for page 70526. And, again, that's the first page of the ASC Quality Reporting Program portion of this final rule.

And here we are. You can see that we are in volume 80, again, on the *Federal Register*. We are on page 70526, and the ASC Quality Reporting Program of this rule, again, begins with Roman numeral XIV. If you scroll down the page on this first column, I want you to know that if you download the PDF document itself, you'll find it contains 311 pages. The ASC portion of this rule begins on page 219 of the PDF.

We are out of the *Federal Register* pages themselves, and we are going to talk about what we have for our program. The ASC Quality Reporting Program has a number of quality measures. Currently, for the calendar

2017 payment determination, which is next year's payment determination, what we have in the rule talks about requirements that apply to payment determinations going forward.

For the calendar year 2017 payment determination, we have 11 measures, and they are listed here. They begin with five quality data code-based measures. They are ASC-1 through 5 patient – Patient Burn; Patient Fall; Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong implant; All-Cause Hospital Transfer/Admission; and Prophylactic IV Antibiotic Timing.

ASC-6 and 7 are web-based measures in that the data is submitted directly to CMS using a web-based tool. ASC-6 is Safe Surgery Checklist Use. ASC-7 is ASC Facility Volume Data on Selected ASC Surgical Procedures.

ASC-8 is a CDC or Centers for Disease Control and Prevention measure. The data for this measure is submitted directly to CDC via their National Healthcare Safety Network site. This is the Influenza Vaccination Coverage among Healthcare Personnel.

ASC-9 and 10 and 11 are also measures where the data is submitted directly to CMS using that web-based tool. ASC-9 is Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients.

ASC-10 is Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps–Avoidance of Inappropriate Use. ASC-11 is a voluntary measure. It is a cataract surgery measure, and it is entitled Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery.

In this rule we did not – we did not propose – in the proposed rule, we did not finalize any new measures for the program. However, we did have measures under consideration. We asked for a comment on two measures. These are a Normothermia Outcome measure and an Unplanned Interior Vitrectomy measure.

Both of these measures received conditional support from the Measures Application Partnership, or MAP, pending the completion of reliability testing and National Quality Forum, or NQF, endorsement. This link will take you to a discussion of these measures, and as noted, we did invite public comment on these measures.

The Normothermia Outcome measure is the percentage of patients having surgical procedures under general or neuraxial anesthesia of 60 minutes or more in duration who are normothermic within 15 minutes of arrival in the post-anesthesia care or PAC unit. Impairment of thermoregulatory control due to anesthesia may result in perioperative hypothermia.

Perioperative hypothermia is associated with adverse outcomes, including cardiac complications, surgical site infections, impaired coagulation, and colligation of drug effects. Maintenance of intraoperative normothermia leads to fewer adverse outcomes and lower overall costs. So this is why this measure is of interest to CMS; it's a very important clinical area to look at, and it has impact on our surgical populations that go to ASCs.

On slide 20, we continue with the Normothermia Outcome measure. As I said, this is a significant area of medical care provided by ambulatory surgical centers. This measure addresses the MAP-identified priority measure gap of anesthesia-related complications. It is currently used in the ASC Quality Collaboration's public reporting program. The specifications for the ASC setting are at this URL and, as stated, we

invited public comment on this measure. We thank you for your comments that were sent.

In this next slide, we begin discussion of the Unplanned Anterior Vitrectomy measure. This measure is the percentage of cataract surgery patients who have an unplanned anterior vitrectomy, which is removal of the vitreous present in the anterior chamber of the eye.

This procedure is performed when vitreous inadvertently prolapses into the anterior segment of the eye during cataract surgery. Rates of this procedure are relatively low, but this complication may result in poor visual outcomes, retinal detachment, and other complications.

Here on slide 22, we outlined why we considered this an important measure. This measure addresses a significant area of medical care provided by ASCs. It addresses the MAP-identified priority measure gap of procedure complications. The specifications for this measure for the ASC setting are here at this URL at the ascquality.org site.

This measure is used in the ASC Quality Collaboration's public reporting program. Again, we invited public comment, and we thank you for the comments that were received.

We move into talking about existing policies, ones that were proposed, and final changes to the program. We discussed codification. A number of our policies were codified this year in the *Code of Federal Regulation*.

Here we provide a listing of topics that were codified. We will touch upon them through this presentation. We looked at the scope and basis of the program; administrative policies including security administrators, participation status, data submission; measure adoption and removal processes; and posting technical specifications on the QualityNet website.

## Support Contractor

We discussed public reporting and the opportunity to view data before data are made public by the ASCs. And we had a proposal that was finalized regarding Indian Health Services hospital outpatient departments not being considered ASCs for the purposes of the program.

So here on slide 25 we begin discussion of some of these areas. We began with the public reporting issues for the program. For the ASC Quality Reporting Program, data will be displayed by the National Provider Identifier, or NPI, when this data is submitted to CMS by NPI.

Data will be displayed by the CMS Certification Number, CCN, when submitted by CCN. We note that we finalized that a CCN's value will not be assigned to all the NPIs associated with that CCN. Instead, we will keep those data separate by the identifier that the information is submitted. We also note that the only data that is submitted by CCN at this time is the CDC's ASC-8, the influenza vaccination measure.

ASCs require a QualityNet account to participate in the program and to receive other valuable information. QualityNet accounts are necessary for submitting data to CMS, for running and reviewing data reports, and for sending and receiving messages via Secure File Exchange. We note here that the Hospital Compare preview reports were distributed utilizing the Secure File Exchange recently, so this is a very important function.

A QualityNet account is necessary for the creating and editing of other user accounts. The Security Administrator provides this function. We recommend submitting required documentation to obtain a Security Administrator four to six weeks prior to any data submission deadline if a Security Administrator is required and your facility does not have one. We codified these existing requirements.

We move to the next slide, slide 27. On slide 27, we look at participation status. An ASC is considered participating once the ASC submits any

quality measure data. This can be via the submission of Quality Data Codes on claims or data that is submitted via an online tool to the ASC Quality Reporting Program.

There is no form that must be completed to be considered participating in the program. ASCs may withdraw from the program at any time up to August 31st of the year preceding a payment determination. We note that to withdraw, ASCs must complete a form. A form is required due to the payment implications of withdrawing from the program because, as we note here, ASCs that withdraw from the program will incur a 2.0 percentage point reduction in the annual payment update for that payment determination year and any subsequent payment determination in which it has withdrawn, and we codified these existing requirements.

ASCs with fewer than 240 Medicare claims per year for a reporting period are not – I repeat – are not required to participate. This means that an ASC would not have to submit Quality Data Codes on claims and would not have to submit measure data via any online tool.

ASCs with greater than 240 Medicare claims per year are required to report data for the following year. I'll note that an ASC can monitor their claims utilizing their Claims Detail Reports and the feedback reports that we supply through the clinical warehouse.

Here on slide 29, we discussed a claims threshold example. Here we have ABC Surgical Center. ABC Surgical Center has 280 Medicare claims in calendar year 2013. This is above the threshold of 240, so this surgical center would have to submit Quality Data Codes on their calendar year 2014 claims. This information will ultimately affect the calendar year 2016 payment determination.

In the next year, 2014, they have 200 Medicare claims. This is below the threshold of 240; therefore, ABC Surgical Center would not have to

submit Quality Data Codes on their claims in calendar year 2015. This is information that would ultimately be used to make payment determinations that would affect calendar year 2017 payment.

Then ABC Surgical Center, once again, exceeds the threshold because in 2015 they have 250 Medicare claims, so they must again submit Quality Data Codes on their claims. Now, they would be submitting Quality Data Codes on their 2016 claims that would ultimately affect their calendar year 2018 payment.

. We realized that this can be confusing if your facility is bouncing between being above and below this threshold. This is the cause for having this ability to not have to participate. The simple solution is to report Quality Data Codes on your claims each year, and then it's not a cause for concern. Alternatively, you can closely monitor your claims volume on your Claims Detail Report.

Here on slide 30, we mentioned some data submission methods that are alternatives to what we currently have in the program. We talked about registries, and we talked about electronic health records and the existence of eCQMs, or quality measures that are specified to be collected electronically.

Currently, there are no ASC quality measure registries in place. We will continue to explore this if a registry is available in the future. We also do not currently know of any ASC quality measures that have been e-specified.

We are also continuing to examine the level of EHR adoption in the ASC community and capability to collect this data if and when measures will emerge.

## Support Contractor

Here on slide 31, we talked about data collection for measures using Quality Data Codes. We do have this method in the program. The data collection period is the calendar year two years prior to the payment determination year.

If you think back to our example, we talked about the claims threshold. We talked about, for example, in a calendar year such as calendar year '13, that data ultimately would affect payment in calendar year 2015. So again, it's that year – two years past when the data is collected.

The threshold for meeting requirements is that 50 percent of an ASC's claims meeting measure specifications must contain appropriate Quality Data Codes, or QDCs. We have left this minimum threshold at the 50 percent level because it allows ASCs that have reporting issues time to recover and still meet program requirements.

We still experience some issues with some ASCs in collecting data in this way; therefore, we have not proposed to raise this threshold from 50 percent and are maintaining it at this time. We codified these existing requirements.

**Matt McDonough:** Thank you very much, Anita. And I'm going to jump in here real quick and drop in our second polling question, if you will. I figure it's a good time to stop and present our second question.

Our question is now visible and the question is this: are you aware that 2015 to 2016 flu data can be entered into the NHSN database?

Here are the results – 84.5 percent, roughly, of you were aware that you could enter this flu data into NHSN. We appreciate knowing that about you all today, and 15.6 percent were unaware, so if you weren't aware and now you know, and we can take that knowledge and move forward with it.

Without further ado, I'm going to go ahead and hand things back to Anita, and we'll get things started on the rest of our presentation. Thanks.

**Anita Bhatia:** Here on slide 32, we discussed data submission via web-based tools. Measures in the program are submitted via this method now. We had proposed to move the deadline for all data submitted via a web-based tool – where that information is submitted directly to CMS – we had proposed to align with the CDC's ASC-8 measure deadline of May 15. That is where that May 15 deadline proposal came from.

In response to this proposal, commenters noted various concerns about technical issues that have occurred. We did not finalize that change, and we are maintaining our deadline of August 15 for all measures submitted to CMS via a CMS online data submission tool.

We did not make any proposals regarding the NHSN measures deadline. We have maintained the May 15 deadline for ASC-8. We have left the May 15 deadline for the ASC-8 measure in that it allows the ASCs to set targets and plan for next flu season. It, also at this time, allows for public reporting before next flu season begins, and it aligns with the Hospital Outpatient and Inpatient Quality Reporting Program.

Here on slide 33, we discussed data collection for the ASC-12 measure. The ASC-12 measure is the Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy. We had previously finalized to begin measurement of ASC-12 with the calendar year 2018 payment determination.

This measure is a fully claims-based measure. It does not require any additional data submission on the part of the facility. ASC-12 uses claims for services furnished in each calendar year that have been paid by the Medicare Administrative Contractor, or MAC, by April 30 of the following year for the ending data collection time period.

We have to write language like this because we are essentially writing legal requirements for the program. What this means, as an example, is that for the calendar year 2018 payment determination, we will be utilizing calendar year 2016 claims. We will utilize calendar year 2016 claims that have been paid by the Medicare Administrative Contactor, or MAC, by April 30 of 2017. We codified this existing requirement.

Under the ASC Quality Reporting Program, we do understand that facilities can experience extraordinary circumstances, so CMS may grant an extension or exemption for data submission in the event of extraordinary circumstances beyond the control of the ASC. When we talk about things that are beyond the control of ASC, we consider things that are acts of nature such as a hurricane.

We also consider systemic problems with one of CMS' data collection systems that may directly or indirectly affect data submission by the facility. Instructions for requesting an extension or exemption are on the QualityNet website, that's the qualitynet.org website, and we codified these existing requirements.

Here on slide 35, we continue with the administrative requirements, and this is the reconsideration process. ASCs may not agree with a payment determination that CMS has rendered, so ASCs may submit a reconsideration request.

The deadline to submit such a request was moved to the first business day on or after March 17 of the affected payment year. The previous deadline was the actual date of March 17, but taking into account weekends and holidays and such, we have moved that to the first business day. This change begins with the calendar year 2017 payment determination, and we finalized that deadline change.

This concludes our discussion of the ASC Quality Reporting Program requirements as outlined in the calendar year 2016 OPPS rule. Now, I will move this discussion back to Tamara.

**Tamara Heron:** Thank you, Anita, for all the wonderful information you have shared with us today. We would like to take some time to share some of the questions that have come in on the chat box during the presentation.

The first question I have today is, "What does it mean to codify?" Anita, would you like to answer this question?

**Anita Bhatia:** Yes, Tamara, I can answer that question. To codify means to collect and systematically arrange the laws, rules, and regulations of a state or county – or country covering a particular area or subject of law or practice.

The *Code of Federal Regulation* is the codification of the general and permanent rules published in the *Federal Register* for the departments and agencies of the federal government. The (code text) recently finalized for the ASC Quality Reporting Program can be found at 42 CFR section 416 under subpart H, Requirements under the Ambulatory Surgical Center Quality Reporting, or ASCQR, Program.

**Tamara Heron:** Great. Here's another question. "If an ASC withdraws, is the two percentage reduction immediate, or does it start with the next payment year?" Anita, do you want to answer that, or do you want me to take it?

**Anita Bhatia:** I can take it. I can (read it).

**Tamara Heron:** Okay.

**Anita Bhatia:** Okay. So, when we talk about an ASC withdrawing from the program, once an ASC has withdrawn, that 2.0 percentage reduction will occur in the ASC's annual payment update for that payment determination year and any subsequent payment determination in which it has withdrawn.

So, for example, if an ASC withdraws on June 15, 2015, the ASC would then sustain the 2.0 percentage reduction in the calendar year 2016 payment year and beyond until the ASC rejoins the ASC Quality Reporting Program.

Please note that an ASC cannot withdraw from the program after August 31st of the year preceding a payment determination.

**Tamara Heron:** We have another question here. "How does an ASC facilitate rejoining the ASCQR Program, and is there a waiting period?" I will answer this one.

An ASC is considered as rejoining, participating, if it begins to submit any quality measure data again to the ASCQR Program. There is no waiting period. Payment determinations will be based on final claims paid by April 30th of that reporting year. Successfully submitting QDCs on at least one paid claim will designate the ASC as participating in the ASCQR Program.

Another question we have here is coming in. "What is the time period that is utilized for claims used for payment determination?" I will take this one as well.

The data collection period for claims-based quality measures using Quality Data Codes is the calendar year two years prior to the payment determination year.

Next question: "During the presentation, there was mention of a minimum threshold, minimum case volume, and data completeness for claims-based measures using QDCs was at 50 percent. Do you anticipate that this minimum threshold will be increased?"

Anita, can you take this one?

**Anita Bhatia:** I can. At this time, CMS is not considering a change in the minimum threshold. CMS believes that having the threshold at 50 percent enables an ASC that has reporting issues during the year time to remedy and recover and still meet the requirements, so we have maintained that 50 percent threshold.

**Tamara Heron:** Perfect. All right. Let's see, another question we have here is: "How do I know if my data collected is credited to my facility for submission?" I will take this one.

We get this question a lot in our call center, and you can run reports to check your facility's data collection. There's one report, called the Provider Participation Report, which will display a summary of the data submissions required for that payment for participation in the ASCQR Quality Reporting Program.

Another option is to check your facility's explanation of benefits or EOBs to ensure that the remittance advice remark code is N620. This code is evidence that the claim has been accepted correctly into the warehouse.

Another resource available is the Claims Detail Report. And this report identifies claims in final action status in the data warehouse. If you're not familiar with this report, there is a short tutorial video on our website on qualityreportingcenter.com, and it's a short video that will walk you through how to run this report, what it is for, and how to use it.

All right. We have another question here. "It was proposed that all data submitted via a web-based tool in the ASCQR Program have a submission deadline of May 15. Was this finalized?"

Anita, can you take this one?

**Anita Bhatia:** Yes, I can. The answer is no; the proposal to have all data submitted via a web-based tool by May 15 was not finalized. The only web-based measure that is due by May 15 at this time is ASC-8, the influenza vaccination coverage measure.

All other web-based measures – ASC-6, 7, 9, 10, as well as 11, which is voluntary – have submission deadlines of August 15.

**Tamara Heron:** Right. "Could you please explain ASC-12 and how it would be captured?" I'll take this one.

The claims-based measure does not – this claims-based measure does not require any additional data submission such as QDCs or the measures submitted on the web-based tool. The payment of services will utilize paid Fee-for Service claims from the calendar year two years prior to the payment determination year.

All right. Next question: "I just want to clarify that Indian Health Services are not considered an ASC for the purposes of the ASCQR Program." I will take this one as well.

Correct. If finalized, Indian Health Services are not going to be considered ASCs for the purposes of the ASCQR Program beginning with the calendar year 2017 payment determination.

All right. Let's look at this question here. "There are two measures under consideration: Normothermia Outcome and Unplanned Anterior Vitrectomy. Will CMS adopt these measures in the future?"

Anita, can you take this one?

**Anita Bhatia:** Yes, I can. CMS seeks to develop a comprehensive set of quality measures that will be used for making informed decisions and quality

improvement in the ASC setting by aligning the measures with the National Quality Strategy and the CMS Strategic Plan.

Both of these measures that are under consideration were developed by the ASC Quality Collaboration. We are considering proposing the adoption of these measures, but the determination as to what CMS will be doing has not yet been made. So, while we are considering these measures for adoption, whether or not that will be proposed is not final, and I would encourage you all to look to next year's rule as to what the plans may be.

**Tamara Heron:** All right. Next question: "What is the minimum number of claims per year that makes reporting mandatory?" I'll take this one.

ASCs with fewer than 200 Medicare claims per reporting period are not required to participate. They do not have to submit Quality Data Codes on claims nor do they have to submit measure data via the online tool on QualityNet.

"Previously, a policy was finalized to post technical specifications on a CMS website and to also post this information on QualityNet. Is this still going to happen?"

Anita, can you take this one?

**Anita Bhatia:** Yes. The answer is no. CMS has decided not to post the Specifications Manual in two different sites. We feel that posting the information on a single site will be more efficient and will provide the ASCs with complete access to the technical Specifications Manual.

Also, having the Specifications Manual on one site will prevent possible inconsistencies related with accessing multiple sites for information and will also reduce burden. We will continue to post the Specifications Manual on the QualityNet site.

**Tamara Heron:** Okay. All right. "Are there any upcoming proposals that will allow ASCs to report their flu data to the CDC using their (NPI) number instead of their CCN number?"

Anita, do you want me to take this one, or do you want to do it?

**Anita Bhatia:** I'll take this. At this time, CMS is going to continue with the use of the CCN for their reporting of their flu vaccination data to CDC. We are continuing to look at this issue, but at this time we are maintaining that that reporting will be done via the CCN.

**Tamara Heron:** Perfect. Okay. I think this is the last question we have – we have time for. "Will CMS provide ASCs more time in which to review their data before public release?" Anita, I'm going to let you speak on this one.

**Anita Bhatia:** All right. Yes. CMS has agreed that ASCs do need a sufficient amount of time to preview their data before public release. We will be considering proposals in future rule-making regarding the preview period and public reporting.

But remember that this review period is just that. It's a review period, and it does not give the facility the opportunity to change data. The review data will be posted as it appears in the preview report; therefore, it's very imperative that ASCs report their Quality Data Codes and other information correctly.

For QDCs, they should be correct before the claims are submitted for payment. In regard to the web-based measure data, those data can be changed up until the data submission deadline.

**Tamara Heron:** Great. Thank you so much for those questions. I think that is going to conclude our presentation today. I would like to, again, thank Anita for all

the information shared today. I just want to go over some continuing education information at this time.

Today's webinar has been approved for one continuing education credit by the boards listed on this slide. We are now a nationally accredited nursing provider and, as such, all nurses must report their own credits to their boards using our national provider number, which is 16578.

We now have an online CE certificate process. You can receive your CE certificate one of two ways -- one, if you're registered for this webinar through ReadyTalk, a survey will automatically pop up when the webinar closes. The survey will allow you to get your certificate.

The other way is we are also going to send out the survey link in an email to all participants within the next 48 hours. If there are others listening to this event that are not registered into ReadyTalk, please forward the survey on to them.

Sometimes, there are some issues with getting your certificate. It may be that your email is being blocked by a firewall, so we do recommend that you go back to the **New User** link and register your personal email account because for some reason personal email accounts are not blocked by firewalls.

This is (what) the survey looks like. It will pop up at the end of the event, and again, it will be sent to all attendees within 48 hours. When you are all done, please click **Done** at the bottom of the page.

This is what pops up when you are done. If you've already attended our webinars and received CEs, please click on **Existing User**. If this is your first webinar, click **New User**.

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This is what the new user screen looks like. Again, please register a personal email like Yahoo or Gmail because these are typically not blocked by firewalls. Just make sure you remember your password because you will use it for all of our events.

This is what the existing user screen looks like. Use your complete email address as your user ID and the password that you registered. Again, just remember your password because you will use it for all of our events. You will then be directed to a link will allow you – that will allow you to print your certificate.

This is going to conclude our presentation for today. We hope you heard some useful information that will help you in your Ambulatory Surgical Center Quality Reporting Program. Thank you and enjoy the rest of your day.