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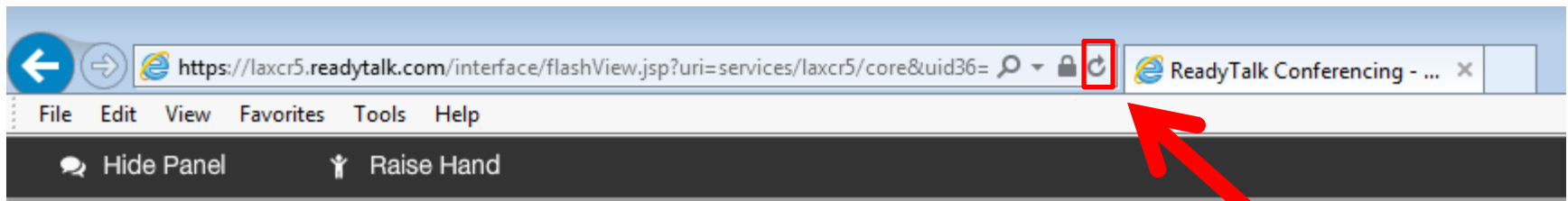
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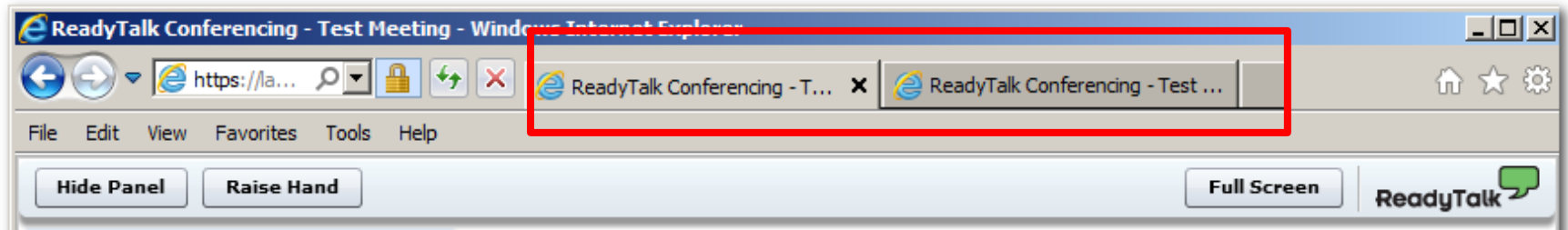


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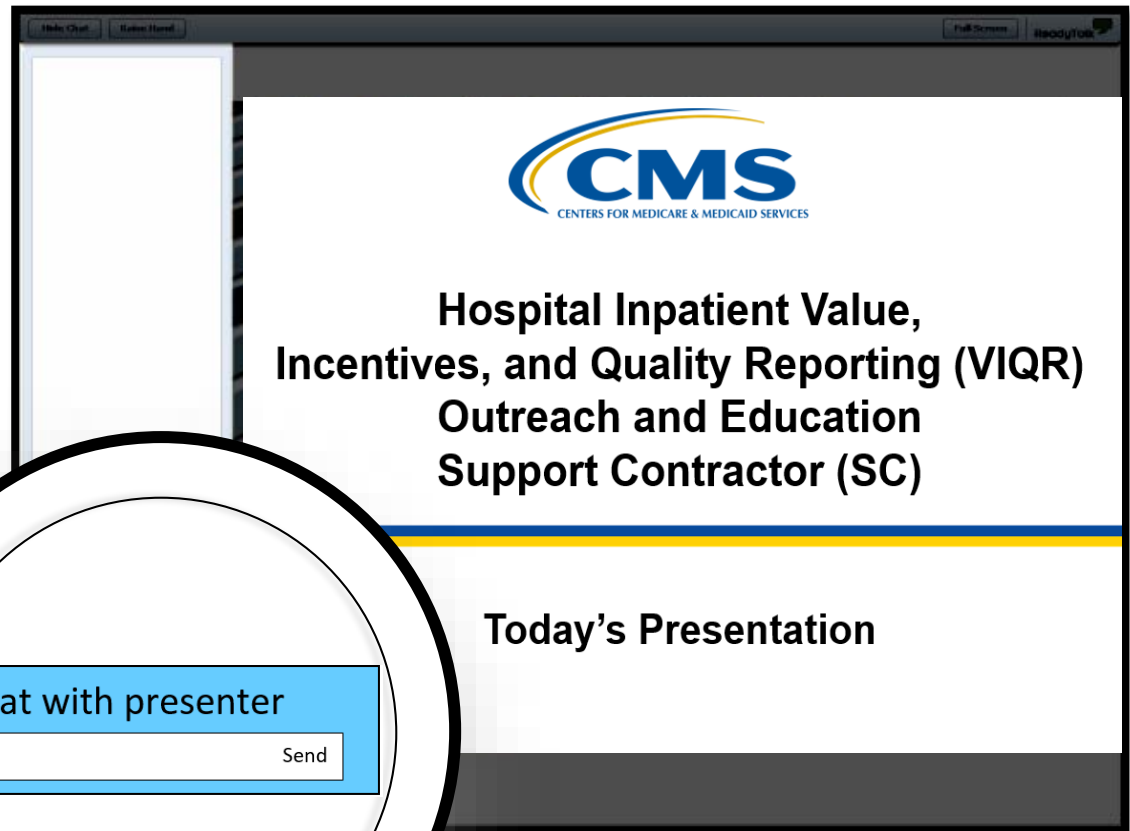
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**SEP-1 Early Management Bundle,
Severe Sepsis/Septic Shock:
Providence Tarzana Medical Center's
Sepsis Journey and
v5.4 Frequently Asked Questions**

July 17, 2018

Speakers

Our Sepsis Journey

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Providence Tarzana Medical Center

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SEP-1 Early Management Bundle, Severe Sepsis/ Septic Shock: v5.4 Measure FAQs

Noel Albritton, MSN, RN

Lead Solutions Specialist
Hospital Inpatient and Outpatient
Process and Structural Measure
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Objectives

At the end of the presentation, participants will be able to:

- Better understand the sepsis journey of Providence Tarzana Medical Center.
- Better understand and interpret the guidance in version 5.4 of the specifications manual to ensure successful reporting for the SEP-1 measure.

Acronyms and Abbreviations

2X	two times	Hg	hemoglobin	PSJSC	Providence St. Joseph Sepsis Collaborative
A&O	alert and orientated	hr	hour	POX	pulse oximetry
AB	antibiotic	HR	heart rate	PRN	as needed
ABX	antibiotic	ICD	International Statistical Classification of Diseases	PTMC	Providence Tarzana Medical Center
Afib	atrial fibrillation	ICU	intensive care unit	Q	quarter
APN	advanced practice nurse	IHI	Institute for Healthcare Improvement	Q2Hx3	every two hours times three
aPTT	activated partial thromboplastin time	INR	international normalized ratio	qSOFA	Quick Sepsis-related Organ Failure Assessment
ARDS	Acute Respiratory Distress Syndrome	IOP	Improving Organizational Performance	R/O	rule out
BMI	body mass index	IV	intravenous	RM	room
BP	Blood Pressure	kg	kilogram	RN	registered nurse
BS	Bowel sounds	L	liter	ROM	risk of mortality
C	Celsius	LOC	level of consciousness	RR	respiratory rate
CBC	complete blood count	MAP	mean arterial pressure	RRT	Rapid Response Team
cc	cubic centimeter	MAR	medication administration record	RVR	rapid ventricular response
CDI	Clinical Documentation Informatics	mcg/L	micrograms/Liter	SBP	systolic blood pressure
CDS	Clinical Documentation Specialist	MD	medical doctor	SCPSC	Southern California Patient Safety Collaborative
CM	Core Measure	MDM	Medical Decision Making	ScVO2	central venous oxygen saturation
CME	Continuing Medical Education	MEWS	Modified Early Warning System	SEP	sepsis
CMO	Chief Medical Officer	mg/d	milligrams/day	SIRS	systemic inflammatory response syndrome
CMS	Centers for Medicare & Medicaid Services	mL	milliliter	SOFA	Sepsis related Organ Failure Assessment
Cx	culture	mmol	millimole	SOI	Severity of Illness
CY	calendar year	MR	medical record	SpO2	peripheral capillary oxygen saturation
dL	deciliter	MRSA	Methicillin-resistant <i>Staphylococcus aureus</i>	STEMI	ST-elevation myocardial infarction
ED	emergency department	NP	nurse practitioner	Temp	temperature
EGDT	Early Goal Directed Therapy	PA	physician assistant	uL	microliter
EHR	electronic health record	PaCO2	partial pressure of carbon dioxide in arterial blood	umol	micromole/liter
ETOH	ethyl alcohol	PI	Performance Improvement	UTI	urinary tract infection
FAQ	frequently asked question	PICC	Peripherally inserted central catheter	UTX	ultrasound
FiO2	fraction of inspired oxygen	PO	by mouth	V	version
g	gram	pO2	partial pressure of oxygen	VO2	oxygen uptake
H&P	history and physical	PSCSC	Providence Southern California Sepsis Collaborative	WTN	within normal limits
H2O	water			YTD	Year to Date
HEENT	head, eyes, ears, nose, throat				

Jamie Eng, M.D.

Associate Director Emergency Medicine, PTMC

Steve Perry, RN

Performance Improvement Review Nurse, PTMC

Our Sepsis Journey

Providence Tarzana Medical Center

- **249-bed acute care hospital accredited by The Joint Commission**
- **24/7 emergency department with ~45,000 annual visits**
- **STEMI receiving center**
- **Primary stroke center**
- **Pediatric medical center**
- **The Valley Heart and Vascular Institute**
- **Women and Children Services**



Care Timeline 2005–2011

2005

- EGDT
- Strong leadership by physicians
- Case review based on EGDT recommendations with referral to peer review

2008

- Development of a multi-disciplinary team: Sepsis Study Group
- Formal integration into the IOP
- Adoption of 2008 IHI sepsis guidelines by study group as new standard of care
- Creation of Sepsis Coordinator position
- Development of Sepsis Rate-Based Report

2009–2011

- Creation and implementation of ED and inpatient Sepsis Order Sets
- Sepsis integrated into annual nursing education update
- Participated in SCPSC
- Development of educational tool for sepsis continuum (physician/nurses)
- Participants in 2011 IHI Sepsis Detection and Initial Management Expedition

Care Timeline 2012

- **Adoption of 2012 IHI guidelines as updated standard of care**
- **Updated Sepsis Order Set**
- **Development and implementation ED physician sepsis template for documentation**
- **Creation of Antibiotics by Source Order Set for sepsis patients based on antibiogram with pharmacy**
- **Stocked key antibiotics in ED pharmacy**
- **Included phlebotomy as part of RRT code**
- **Developed policy and procedure for dedicated RRT**
- **Expansion of Sepsis Study Group to include hospitalist group**
- **Providence System audit-high performer compliance with sepsis abstraction guidelines**

Care Timeline 2013–2015

- **Participation in PSCSC**
- **ED and hospitalist sepsis presentations to general medical staff**
- **Educational reminders to ED and Department of Medicine regarding sepsis**
- **Close collaboration among CMO, hospitalists, and ED providers regarding target metrics**
- **Educational lecture regarding SEP-1 core measure to general medical staff**
- **Development of 3 and 6 hour severe sepsis and septic shock algorithm**
- **Refinement of RRT's role in early identification**
- **Key antibiotics to floors to expedite care (Pyxis)**
- **Collaboration with CDS to ensure accurate documentation in sepsis patients**
- **Hosted the Sepsis Simulator Mobile classroom**
- **Started collecting ROM and SOI data on all cases**
- **Participated in Premier analytics webinar regarding calculation of O/E mortality**
- **June 2015 CMS Webinar: Early Management Bundle, Severe Sepsis/Septic Shock**

Care Timeline 2015–Today

SEP-1 Bundle

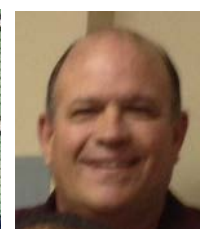
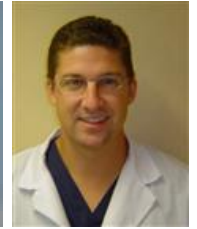
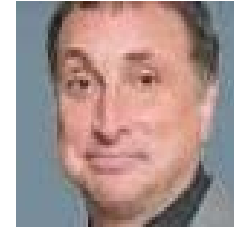
- Data collection beginning 2015 Q4 by PI department
- Second update of SEP-1 measure to general medical staff
- Weekly work group including nursing, lab, radiology and ED MD's regarding core measure compliance
- Addition of SEP-1 measures to nursing resource binder
- Education letter regarding SEP-1 guidelines and changes developed for medical staff
- Development of standardized ED documentation template

2015–Today

- Refinement of ED Sepsis Order Set and Antibiotics by Source Order Set
- Development of CODE SEPSIS in the ED
- Development of sepsis checklist for ED nursing to ensure completion of bundle components
- Developed sepsis watch list
- Refinement of template to address CMS requirements for recognition time and septic shock reassessment
- Participation in PSJSC

Sepsis Study Group

- CMO
- Hospitalists
- Laboratory
- Nursing Leadership
- Quality and PI
- Respiratory
- ED Leadership
- Coding and CDI
- Sepsis Coordinator



Sepsis Study Group

- **Multi-disciplinary**
- **Key stakeholders**
- **Regular monthly meetings under medical staff**
- **Review of system data and internal data**
- **Review of trends and processes**
- **Actionable items, reportable to the next meeting**

Sepsis Coordinator

- **Position created to monitor and improve treatment and chart documentation**
- **Increasing role through the years**
- **Assists in providing nursing education**
- **Daily sepsis screening with inpatient charge nurses**
- **Does inter-rater reliability with abstractor**
- **Contemporaneous chart review**
- **Collaboration with key stakeholders to ensure timely treatment and management**

Sepsis Rate Base Report

ED Patients and Inpatients - 2017

		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Sample size		16	12	15	16	12	14	12	12	13	16	15	17	170
ER RESUSCITATION BUNDLE	BMK													
	N	16	12	15	16	12	14	12	12	13	16	15	17	170
1. % of patients met lactate standard.		94%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99.0%
	N	16	12	15	16	12	14	12	12	13	16	15	17	170
2. % Blood culture before ABX		94%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99.0%
	N	16	12	15	16	12	14	12	12	13	16	15	17	170
3. % ABX timeliness (ED = 180 min)		94%	100%	100%	100%	92%	100%	92%	100%	100%	100%	100%	100%	98.2%
	N	15	12	15	15	12	14	12	12	13	16	15	17	168
4. % Correct Antibiotic Selection		100%	100%	100%	100%	100%	100%	92%	92%	100%	94%	100%	94%	97.6%
	N	7	8	13	14	12	11	4	8	10	12	9	11	119
5. % repeat lactate done		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	91%	99.1%
	N	4	2	4	5	3	3	4	6	2	9	5	5	52
6. % Fluids administered (30 ml/kg.)		75%	100%	75%	100%	100%	67%	100%	83%	50%	89%	80%	80%	84.6%
	N	1	0	0	0	0	0	1	0	0	0	1	1	4
7. % Vasopressors administered.		100%	NM	NM	NM	NM	NM	100%	NM	NM	NM	100%	100%	100.0%
	N	4	2	4	4	3	3	2	2	2	5	4	5	40
8. % Post fluid administration reassessment done.		75%	50%	75%	100%	100%	67%	100%	100%	100%	100%	100%	80%	87.5%

Sepsis Rate Base Report

ED Patients and Inpatients - 2017

OUTCOME SUMMARY (ER CM)		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
	N	16	12	15	16	12	14	12	12	13	16	15	17	170
1.	% That Passed The Measure	69%	92%	93%	100%	92%	93%	83%	83%	92%	94%	93%	82%	88.8%
2.	# Survived severe sepsis and/or septic shock.	15	11	14	16	12	13	11	11	12	15	15	17	162
3.	Mortality rate.	6%	8%	7%	0%	0%	7%	9%	9%	8%	6%	0%	0%	5.8%
4.	Quarterly mortality rate			7%			2%			8%			2%	
OUTCOME SUMMARY (ALL patients ER + inpat)														
1.	Total # of Cases (CM)	17	14	15	16	15	15	14	15	15	18	17	18	189
2.	# Patients that Survived (CM)	15	13	14	16	15	14	13	13	13	15	17	18	176
3.	# Patients that Expired (CM)	2	1	1	0	0	1	2	2	2	3	0	0	14
4.	Total Mortality Rate (all CM Patients)	11.7%	7.1%	6.9%	0.0%	0.0%	6.6%	13.3%	13.3%	13.3%	16.7%	0.0%	0.0%	7.3%
5.	# Severe Sepsis Patients Expired (CM)	0	1	0	0	0	1	2	0	1	2	0	0	7
6.	Severe Sepsis Mortality Rate (CM)	0%	8%	0%	0%	0%	8%	15%	0%	8%	17%	0%	0%	4.8%
7.	# of Patients With Septic Shock (CM)	8	2	4	4	3	3	2	3	2	6	4	5	46
8.	Septic Shock Mortality Rate (CM)	25.0%	0.0%	25.0%	0.0%	0.0%	0.0%	0.0%	66.6%	50.0%	16.7%	0.0%	0.0%	15.2%
9.	Mortality rate for all coded with Severe sepsis or Septic shock. (Info-view)	21%	17%	14%	13%	7%	24%	16%	12%	21%	23%	16%	8%	15.9%

- Line 7 under outcome summary is a sub-set of line 1.
- Line 4 is the total mortality for patients included in the core measure.
- Line 9 is the mortality for all patients coded with Severe Sepsis and Septic Shock, not limited to the core measure sample.

Data Collection Tool for PI Abstraction 2009–3Q 2015

PROVIDENCE Tarzana Medical Center		Sepsis Data Collection Tool (Sepsis PI Dashboard Elements)	
MR#		Triage Time:	
DATE OF ADMIT			
DATE OF DISCHARGE			
RESUSCITATION BUNDLE (WITHIN 6 HOURS)			
15R	LACTATE LEVEL DONE, RESULTED AND REPORTED TO MD WITHIN 6 HOURS	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Denominator: Number of patients who should have lactate level done. Number of patients with severe sepsis.
15S	BLOOD CULTURES DRAWN BEFORE ABX ADMIN.	<input type="checkbox"/> YES <input type="checkbox"/> NO	Denominator: Number of patients presenting with severe sepsis and / or septic shock.
15T	TIME TO BROAD SPECTRUM ABX FROM TIME OF PRESENTATION	_____ MINUTES	Median time in minutes to be reported One hour for non-ED admits, 3 hours for ED admit.
15U & 15V	FLUID RESUSCITATION: INITIAL MINIMUM OF 20 ml/kg CRYSTALLOID OR COLLOID FOR HYPOTENSION AND OR LACTATE LEVEL > 4mmol/L (36 mg/ dl) AND OR VASOPRESSORS FOR HYPOTENSION AND OR LACTATE LEVEL > 4mmol (36 mg / dl) TO MAINTAIN MAP > 65. (SBP >= 90)	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Denominator: Number of patients with hypotension (SBP < 90 or MAP < 65 and /or lactate level > 4mmol/L, not responding to initial fluid resuscitation.
15W	SEVERE SEPSIS, LACTATE >4mmol OR SHOCK PRESENT, IN WHICH CVP > 8mmHg ACHIEVED WITHIN 6 HRS.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Denominator: Number of patients with severe sepsis and lactate level > 4 or septic shock. Exclusion: patients with non-severe sepsis or lactate level < 4mmol/L.
15X	SEVERE SEPSIS, LACTATE >4mmol OR SHOCK PRESENT, IN WHICH ScVO2 > 70%, or SvO2 > 65% ACHIEVED IN 6 HRS. FROM TIME OF PRESENTATION	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Denominator: Patients with severe sepsis and lactate > 4mmol/L or septic shock. Exclusion: Non severe sepsis or lactate < 4 mmol/L.
MANAGEMENT BUNDLE (WITHIN 24 hours)			
15Y	SEPTIC SHOCK PRESENT. LOW DOSE STEROID ADMINISTERED PER ICU POLICY WITHIN 24 HRS. OF PRESENTATION.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Denominator: Total number of patients with septic shock.
15Z	SEVERE SEPSIS OR SHOCK PRESENT. DROTRECIGIN ALFA(activated) ADMINISTERED PER POLICY WITHIN 24 HRS. OF PRESENTATION	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Denominator: Total number of patients presenting with severe sepsis or septic shock who are given Xigris per policy.
15AA	SERUM GLUCOSE MAINTAINED GREATER THAN 70mg/dl AND WITH A MEDIAN VALUE < 150mg/dl OVER THE FIRST 24 HOURS FOLLOWING PRESENTATION.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Denominator: total number of patients presenting with severe sepsis or septic shock.
15BB	SEVERE SEPSIS OR SHOCK PRESENT. MECHANICALLY VENTILATED WITH IPP, 30 cm H2O OVER THE FIRST 24 HOURS FOLLOWING PRESENTATION.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Denominator: Number of mechanically ventilated patients presenting with severe sepsis or septic shock.
15CC	SURVIVED SEVERE SEPSIS AND OR SEPTIC SHOCK	<input type="checkbox"/> YES <input type="checkbox"/> NO	Denominator: total number of patients with severe sepsis or septic shock.

Data Abstraction

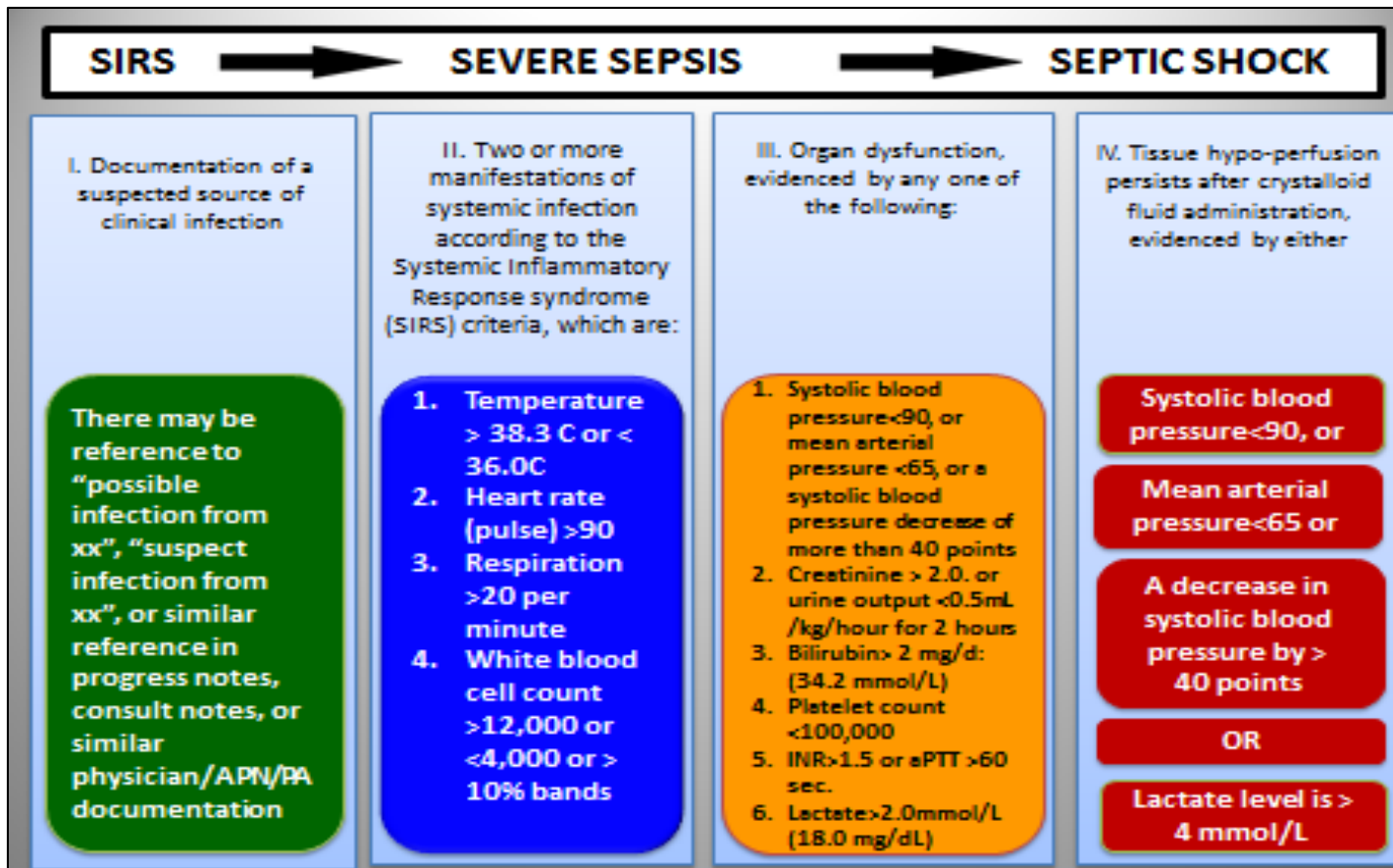
- Prior to the SEP-1 quality measure, all cases with ICD coding of severe sepsis and septic shock (typically 60–80 cases per month) were abstracted.
- Primary sepsis abstractor frequently submits queries to CMS through *QualityNet* for the purpose of clarification during case abstraction and for consultation when developing physician and staff documentation tools.
- For the purpose of inter-rater reliability our Sepsis Coordinator abstracted in parallel five of our 22 SEP-1 cases per month to compare results with sepsis primary abstractor.
- Primary abstractor identifies missed measures monthly and forwards initial write-up to peer review RN for verification before physician review.
- Primary abstractor completes rate-based report monthly, tracks and trends missed measures, and archives raw data.

Teaching Tool Based on 2008 Institute for Healthcare Improvement Guidelines

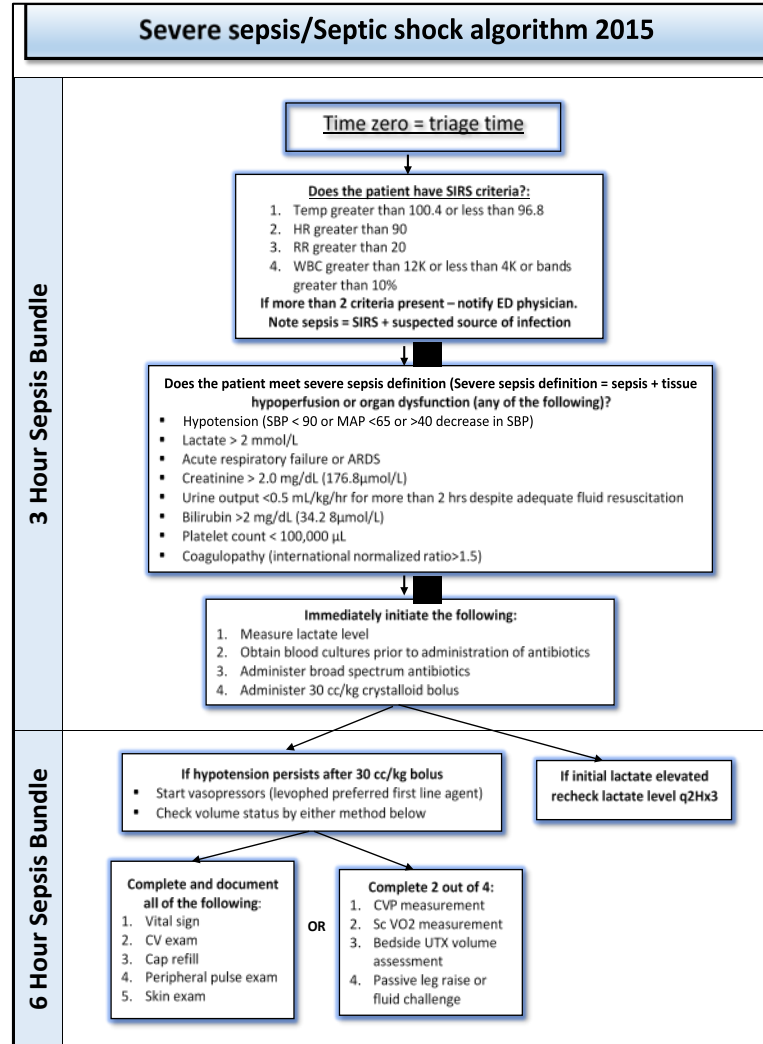
SEPSIS CONTINUUM

<p>SIRS</p>	<p>Systemic Inflammatory Response Syndrome</p> <p>Defined by the presence of two or more of the following:</p> <ol style="list-style-type: none"> 1. Temperature > 38 degrees C or < 36 degrees C 2. Heart rate > 90 beats/ minute 3. Respiratory rate > 20 breaths / min or PaCO2 < 32 mm Hg 4. Leukocyte count > 12,000, <4,000 or > 10% bands
<p>SEPSIS</p>	<p>SIRS plus a suspected or confirmed site of infection, Examples: Urinary tract infection, Pneumonia, Decubitus ulceration</p>
<p>SEVERE SEPSIS</p>	<p>Defined as: Sepsis with organ system dysfunction (examples below)</p> <ul style="list-style-type: none"> • Altered LOC (<i>increased agitation, confusion, decreased Glasgow Coma Score</i>) • Renal failure/ insufficiency (<i>Creatinine > 2.0 and/ or urine output <0.5 ml/kg/hour</i>) • Respiratory failure (<i>room air pulse oximetry < 92%, pO2/ FiO2 <300, need for mechanical ventilation</i>) • Metabolic/ Hepatic/ Hematologic. (<i>Lactate level >2.0, liver enzymes >2X upper limit of normal, Platelet count < 100k, INR> 1.5 w/o Warfarin</i>) <p>Order: Lactic acid , Blood Cx prior to ABX, Early fluid (20ml/ Kg) and antibiotic</p> <p>Antibiotic administration: (ED <3 hours inpatient < 1 hour)</p>
<p>SEPTIC SHOCK</p>	<p>Septic Shock and/or Severe Sepsis w/ Lactate > 4.0</p> <p>Defined As: Severe sepsis with SBP < 90 unresponsive to initial fluid resuscitation and/ or lactate level > 4.0</p> <p>Order: Lactic acid , Blood Cx prior to ABX, Early fluid (20ml/ Kg) and antibiotic</p> <p>Antibiotic administration: (ED <3 hours inpatient < 1 hour)</p> <p>Use printed septic shock order set for ED or inpatient</p>

Sepsis Continuum



Providence Tarzana Medical Center 2015 Algorithm



Educational Letter to the Department of Medicine

Dear Member of the Department of Medicine:

The medical staff and hospital leadership of PTMC are committed to providing the safest and best care for our patients. As of October 2015 discharges of Severe Sepsis/Septic Shock Management are a Core Measure. On the reverse side of this document we have attached some slides that may be beneficial for your review;

- The first slide is from the Joint Commission/CMS that simplifies the requirements of the 3 hour and 6 hour bundle. You will also note that the measure is an “**all or nothing**” measure.
- The second slide describes the continuum of symptoms from SIRS to Septic Shock.
- And the third slide describes how the “**start time**” is determined.
- After review of multiple cases starting in October/2015 the following items/issues have been recognized and found to be problematic and have resulted in fallouts:
- You will note that on the third slide listed on the back the start time can be determined two ways: The start time is when either the third element of clinical criteria is documented within a 6 hour time frame or the MD documents a diagnosis of “severe sepsis or septic shock”. During review we have noted the following:
 1. In the absence of clinical criteria being met in the chart, if the physician documents a diagnosis of severe sepsis/septic shock the start time is the time the physician opens the note that contains the diagnosis. (**Please note: if the physicians specifies a time of diagnosis within the document – then that time is the start time**). If the physician documents severe sepsis/septic shock he/she must start treatment as described on the first slide on the reverse of page.
 2. If blood cultures were not drawn within 24 hours of diagnosis – they must be repeated.
 3. If a lactate has not been done within 6 hours of diagnosis, you must order a lactate and repeat within 6 hours if greater than 2.0.
 4. If not on IV antibiotics – the antibiotic must be ordered and administered within 180 minutes of diagnosis.
 5. Be aware if a patient experiences hypotension or lactate greater than or equal to 4.0 a fluid bolus of normal saline or lactated ringers in the amount of 30ml/kg is required.
- The most common patient to fail the management bundle is a patient that is diagnosed after admission on the medical/surgical/telemetry floor. **So, when you are either contacted by the staff or make the diagnosis of severe sepsis/septic shock – ask that the Rapid Response team (RRT) be called to manage administration of the bundle elements.** If the patient is already in a critical care unit notify the nurse to initiate the sepsis bundle.

I hope this information is of value to you. If you want any additional information please contact. In addition there is on-going continued discussion on this topic at the both the Department of Medicine and the Medicine Peer and Chart Review Committee.

Respectfully,

Sepsis Watch List

The attached EPIC-generated list includes patients who might be on your floor and should be reviewed by the charge nurse for **possible** (*at high risk for*) severe sepsis or septic shock:

- Patients that appear on this list have been **flagged by EPIC with sepsis alerts** or have other indicators for sepsis including: **MEWS, SOFA, QSOFA, Procalcitonin, and/or elevated lactic acid.**
- Patients listed may not require sepsis orders but have been selected as “**at risk**” for possible sepsis.
- Timely recognition and treatment are essential and required by joint commission.
- **Please ask MD and/or review your patient charts for any documentation by physicians of a diagnosis of severe sepsis or septic shock.**
 1. If lactic acid is elevated (> 2) please ensure a repeat is drawn within 6 hours of first.
 2. Before starting antibiotics verify that cultures have been drawn within the past 24 hours.
 3. Fluid bolus may be required for new sepsis recognition at 30ml/kg.
- **Please notify RRT with any case of suspected sepsis or newly recognized severe sepsis or septic shock diagnosis.**
- RRT can assist with protocol orders.
- ***Inpatient sepsis constitutes the bulk of core measure fallouts. Please do your part to assist in the timely and proper treatment of septic patients.***

Please direct questions or concerns by activating **Rapid Response XXX-XXX-XXXX.**

Note:

Symbol of lightning = Possible sepsis

Symbol of lightning and red dot = Possible severe sepsis

ED and Inpatient Order Sets

- **ED Sepsis Order set and ED Antibiotics by Source set**
- **Created to address provider work flow and compliance**
- **Implemented by ED leadership**
- **ED providers educated regarding its use**

Sepsis Order Set (1 of 2)

Order Sets

Sepsis Complete Manage My Version ▾ ⤴

▾ General

▾ Sepsis Management

Sepsis management
P Details

▾ Nursing

Enhanced vital signs:

Sepsis notification parameters

▾ Studies

▾ Lab

Comprehensive Metabolic Panel
STAT

Magnesium
STAT

Phosphorus
STAT

CBC with Differential
STAT

Protome INR
STAT

Lactic Acid
STAT, EVERY 2 HOURS INTERVAL for 2 occurrences

Procalcitonin
STAT

Blood Culture Panel

Culture, Respiratory, Lower, Smear
STAT

▾ Imaging

XR Chest AP Portable
STAT

Sepsis Order Set (2 of 2)

▼ Fluid Boluses

▼ Sepsis Fluid Bolus with Fluid Rounding

- Fluid Bolus 100-116kg 3.5L
- sodium chloride 0.9% - BOLUS ONCE NOW
30 mL/kg, Intravenous, Administer over 1 Hours, ONCE
- sodium chloride 0.9% - PRN BOLUS
500 mL, Intravenous, Administer over 15 Minutes, PRN, See Administration Instructions, Bolus based on parameters specified. HOLD bolus if patient meets criteria for bolus but CV greater than 3L / 12 hours or if SpO2 drops > 3%

▼ Antibiotics

For Pneumonia:
Anaerobic coverage is not indicated in the setting of micro-aspiration events. May consider utilization of agents with anaerobic spectrum in the setting of suspected lung abscess, post-obstructive pneumonia or large volume witnessed aspiration preceding pneumonia.

- ▶ Pneumonia - Non-ICU
- ▶ Pneumonia - ICU
- ▶ UTI - Uncomplicated
- ▶ UTI - Complicated
- ▶ Intra-Abdominal Infection
- ▶ Skin and Soft Tissue Infection
- ▶ Meningitis
- ▶ Febrile Neutropenia
- ▶ Sepsis of Unknown Etiology

▼ Vasoactive Medications

**This patient does not appear to be in a critical care unit or the ED.
The orders in this section will likely require a higher level of care.**

▼ Vasopressors (preferred)

- norepinephrine (LEVOPHED) infusion - 1st line
1-30 mcg/min, Intravenous, TITRATED, Taper vasoactive agents off in reverse order of initiation.
- EPINEPHrine infusion - 2nd line
1-10 mcg/min, Intravenous, TITRATED, Taper vasoactive agents off in reverse order of initiation.
- vasopressin - as ADJUNCT to norepinephrine
0.03 Units/min, CONTINUOUS, DO NOT TITRATE. Must be used WITH norepinephrine infusion. Stop when MAP goal achieved and norepinephrine is < 15 mcg/min. Taper vasoactive

Documentation Template

- **Created to ensure specific documentation elements by ED providers**
- **Initial draft reviewed and edited by education committee**
- **Implemented by ED leadership**
- **ED providers educated regarding its use**
- **Frequent revisions based on PI department review, CMS queries, and updated guidelines**
- **Contemporaneous provider feedback when template not used or components missing**

ER MD Sepsis Documentation Template

Admit MDM:

Severe Sepsis criteria:

Infectious source: _____

End organ damage indicated by: _____

- Labs are pulled into template document:

Sepsis Management:

Time of recognition of severe sepsis/septic shock: _____

Within 3 hours of recognition:

Blood cultures x 2 before broad-spectrum antibiotics: (YES/NO)

30 ml/kg NS bolus

Initial lactate: _____

Repeat lactate: _____

Septic Shock Assessment:

Any lactic acid ≥ 4.0 (YES/NO)

Persistent hypotension: (SBP < 90 or 40 mmHg drop, MAP < 65) despite 30 mL/kg IV fluid bolus (YES/NO)

A focused sepsis perfusion/reperfusion reassessment examination was performed post 30ml/kg bolus @ 00:00:

- Temp
- BP
- HR
- RR
- Pox

CODE SEPSIS

- **Created to ensure sepsis patients receive immediate diagnostics and treatment**
- **Overhead paged within ED if suspected or confirmed**
- **Temporary re-allocation of nursing resources to assist the primary nurse**

ED Nursing Sepsis Checklist

- **Created to ensure SEP-1 bundle components met in ED prior to transfer**
- **Closes loop of communication between RN and MD**

ER CODE SEPSIS Checklist (Part 1 of 2)

If your patient presents with SIRS criteria:

Temperature 100.9 or below 96.8 / Heart Rate > 90 / Respirations > 20 / WBC > 12000 or < 4000 or > 10% bands

Indications sepsis. ED MD should be started on a Sepsis work up. The following lab values signify organ dysfunction elevating sepsis to severe sepsis in the setting of the SIRS criteria **requiring core measure items:**

Lactate > 2.0 / hypotension < 90 or decrease of > 40 points / Creatinine > 2.0 / Billirubin > 2 / Platelet < 100k / INR > 1.5 / aPPT > 60

Sepsis core measure items must be addressed in ED within the first 3 hours.

1. Blood Cultures drawn (**before antibiotics**) please chart cultures drawn before AB
2. 30ml/kg bolus required for Lactic Acid > 4 (at MD discretion if lactate >2 but < 4)
3. Antibiotics started
4. Lactic Acid drawn, results over > 2. **require** repeat draw done within 6 hours of arrival
ED typically orders serial lactate Q 2 hour

Please when handing off from ED on a diagnosis of severe sepsis please be specific about the status of a **repeat lactic acid** if not resulted in ED.

1. Was the repeat lactic acid ordered in the ED?
2. When does it need to be drawn to be within the 6 hour window?
3. Admit orders may sometimes cancel out ED orders please ensure an order for the stat repeat Lactic Acid is still pending in EPIC > advise accepting RN.

After the crystalloid fluid bolus 30ml per kg patient still exhibits Persistent hypotension < 90 or decrease of > 40 points or lab results Lactate > 4 patient is considered to exhibit septic shock. Please assist the MD to consider vasopressors and a central line.

Preferred Sequence of Antibiotic Administration for Sepsis Patients

Check for drug reactions & allergies

Multiple antibiotics start a second line do not mix antibiotics in one line

Give antibiotic with broadest coverage and shortest infusion rate first

15 minute infusion: **meropenem**

30 minute infusion: **ceftriaxone, cefazolin, metronidazole, gentamicin, clindamycin, Unasyn, Zosyn 3.735g.**
From Pharmacy: Zosyn 2.25 & 4.5g, ceteprime

60 minute infusion: **azithromycin, levofloxacin 250-500mg.** **From Pharmacy: Aztreonam**

90 minute infusion: **levofloxacin 750mg**

60 minute infusion: **(90 minute preferred): Vancomycin 1g**

ER CODE SEPSIS Checklist (Part 2 of 2)

TIME CODE SEPSIS CALLED : _____	
Blood Cultures x 2 <ul style="list-style-type: none"> Documentation of blood cultures drawn Drawn before administration of AB 	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO Time of draw _____
Lactic Acid - any value > 2 requires repeat Report state the status of the repeat Lactic Acid inpatient RN <input type="checkbox"/> YES <input type="checkbox"/> NO	Initial lactic acid: _____ time: _____ repeat lactic acid: _____ time: _____
Fluid bolus 30ml/kg within 3 hours Reported status of fluid bolus to inpatient RN <input type="checkbox"/> YES <input type="checkbox"/> NO	patients charted weight: _____ kg expected fluid bolus: _____ ml time bolus start: _____ time bolus ended: _____
Antibiotics All must be given within 3 hours <ul style="list-style-type: none"> if multiple antibiotics administer per pharmacy recommendations (see reverse) 	time of administration #1: _____ time of administration # 2: _____ time of administration # 3: _____
Vasopressors within 6 hours	time of vasopressor administration _____ central line <input type="checkbox"/> YES <input type="checkbox"/> NO
MD reassessment <ul style="list-style-type: none"> volume reassessment by MD MD confirmation that patient is ready to transfer to floor 	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO time transported _____

Rapid Response Team

- **Incorporate MEWS 4 or higher into rapid response process**
- **Screen patient and communicate findings to admitting MD**
- **Initiate SEP-1 bundle if applicable**
- **Assist inpatient nursing in early identification and management of possible sepsis patients**

Peer Review

- **Protected**
- **Contemporaneous chart reviews**
- **Case reviewed by ED leadership with immediate feedback to provider in case of fallout**
- **All fallouts reviewed during ED Committee meeting every two months**

Performance

- SEP-1 bundle compliance
 - 2017 YTD: **81.28%**
- YTD mortality rate
 - 2017: **16.18%**
 - All patients except hospice
 - 2011 YTD: **28.28%**
 - Relative reduction in mortality over seven years: **42.78%**

Summary:

What Did We Do? (1 of 2)

- **Monthly multi-disciplinary meetings: pharmacy, coding, nursing, RRT, and laboratory**
- **Sepsis Coordinator**
- **Real-time chart review and feedback**
- **Peer-review process for Department of Medicine and ED**
- **Involved coders and CDI breakdown of processes**
- **Auditor review**
- **Sepsis simulator mobile classroom**
- **Auditor review**
- **Educational booklet**
- **Order Set development**
- **Developed rate-based report**

Summary:

What Did We Do? (2 of 2)

- **Data collection tools**
- **Documentation template**
- **Frequent queries to CMS for clarity with immediate implementation to practice and work-flow**
- **Creation of sepsis template for physician use**
- **Sepsis nursing checklist**
- **CODE SEPSIS in the ED**
- **Sepsis watch-list**
- **Sepsis continuum**
- **Presentation by physicians both internal and external (CME)**
- **Education to Department of Medicine, Medical Executive, and General Staff meetings**

Lessons Learned

- **Multidisciplinary team**
- **Physician-driven participation**
- **Strong nursing leadership**
- **Frequent standardization/templates/compliance tools**

Future Considerations

- **PSJH Sepsis Collaborative**
- **Sepsis unit with dedicated sepsis staff**
- **Consideration of SEP-3 definitions**

Howard Davis, M.D., M.B.A, Chief Medical Officer
Providence Tarzana Medical Center

Challenges

Challenges

- **Independent Medical Staff**
- **Resources**

Andre Vovan, M.D., M.B.A.
Regional Chief of Clinical Effectiveness
Providence St. Joseph Health, SoCal

Future Considerations

Future Considerations

- **Decrease in mortality, cost, and variation in care**
- **“Fast Alone, Far Together”**
- **Sepsis mortality**

Challenges: Decrease Mortality, Cost and Variation in...



50 Hospitals

- 8 Critical Access
- 7 > 500 bed
- 13 < 100 bed
- Rural, Urban, Suburban, Remote settings (e.g., Kodiak Island, Alaska)

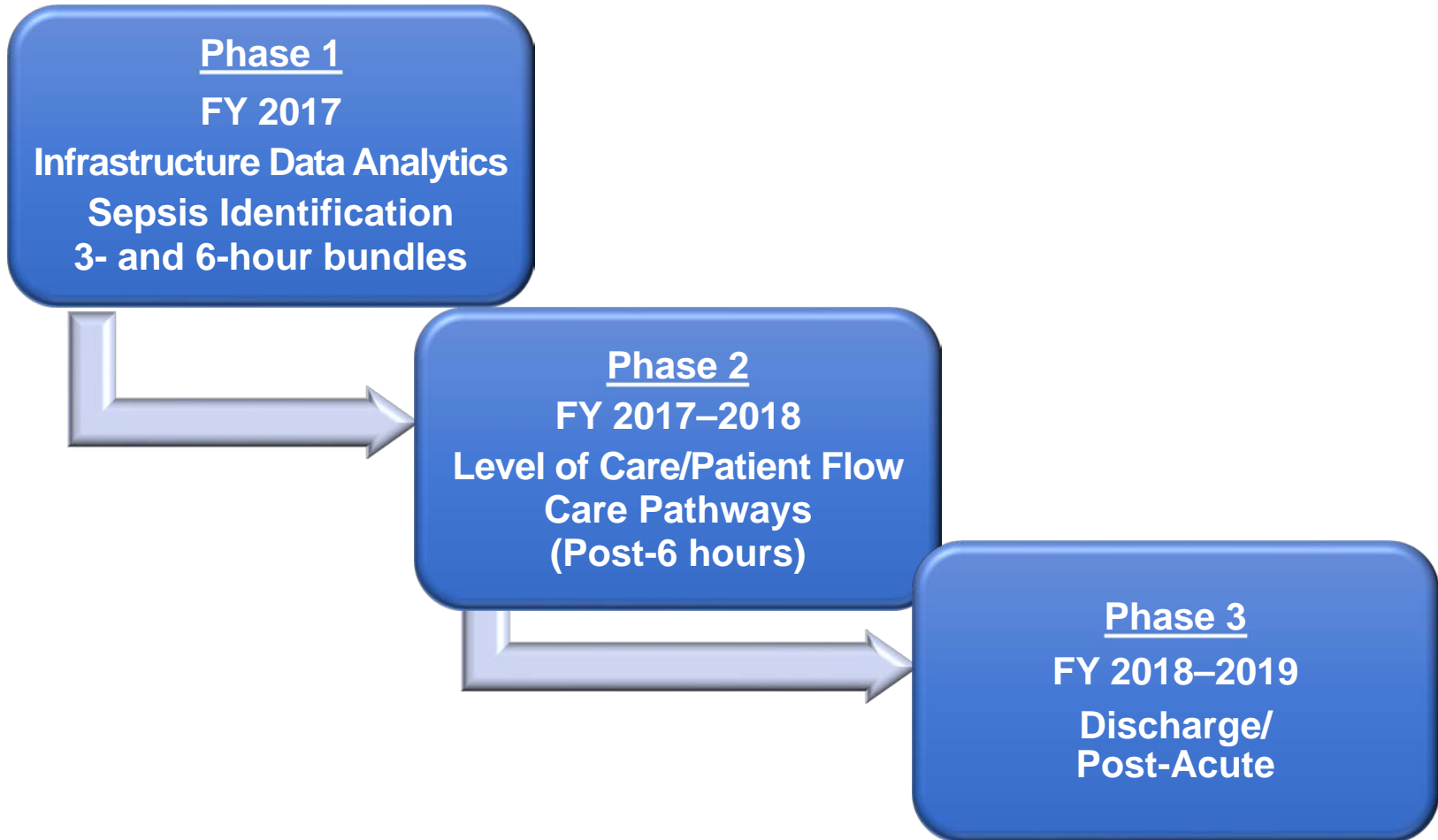
Provider Mix

- ED MDs
- Hospitalists
- Intensivists
- Nurses/APN/PAs
- Primary Care

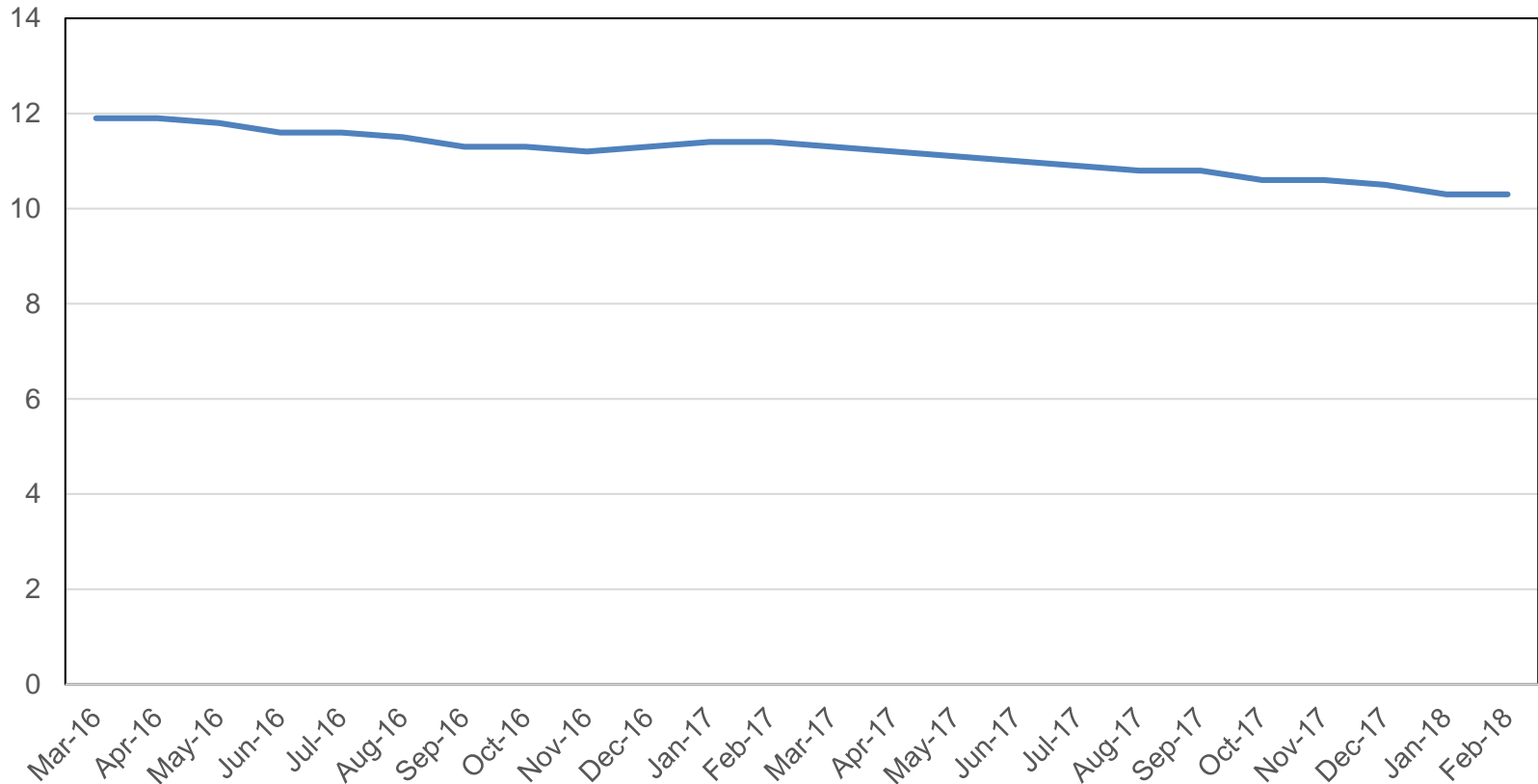
Multiple EHRs

- EPIC (3 instances)
- Meditech (3 regions)
- Allscripts

Sepsis Collaborative: A Phased Approach to “Fast Alone, Far Together”



Providence St. Joseph Health Sepsis Mortality Rate



Thank You

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SEP-1 Early Management Bundle, Severe Sepsis/Septic Shock:
Providence Tarzana Medical Center's Sepsis Journey
and v5.4 Frequently Asked Questions

SEP-1 v5.4 Frequently Asked Questions

SEP-1 Public Reporting

- SEP-1 overall hospital performance public reporting begins with the July 2018 *Hospital Compare* release.
- The quarters publicly reported for this release are 1Q 2017 through 3Q 2017.
- With each release, the most recent quarter is added and older quarters removed so a full rolling year's worth of performance data are included, similar to other chart abstracted measures.
- The first full year of data will be in the October 2018 release when the full CY 2017 will be reported.

Blood Culture Collection v5.4

Q: If the Severe Sepsis Presentation Date and Time is 7/1/18 at 0900 and the patient received an IV antibiotic 7/1/18 at 0930, what is the timeframe for abstracting the blood culture collection?

A: Timeframe for abstracting Blood Culture Collection:
24 hours before the Severe Sepsis Presentation Time through 3 hours after the Severe Sepsis Presentation Time.

Blood Culture Collection v5.4

Example:

Blood Culture Collection Time: 7/1/18 at 0600

Severe Sepsis Presentation Date and Time is 7/1/18 at 0900

IV antibiotic at 7/1/18 at 0930

Timeframe for Blood Culture Collection:
6/30/18 at 0900 through 7/1/18 at 1200

Blood Culture Collection = value “1” (Yes)

Blood Culture Collection Date = 7/1/18

Blood Culture Collection Time = 0600

Blood Culture Collection v5.4

Q: If the patient received an IV antibiotic 7/1/18 at 2100 and the Severe Sepsis Presentation Date and Time is 7/2/18 at 0900, what is the timeframe for abstracting the blood culture collection?

A: Timeframe for abstracting Blood Culture Collection:
24 hours **prior** to the administration of the **antibiotic** through 3 hours following Severe Sepsis Presentation Date and Time.

Blood Culture Collection v5.4

Example:

Blood Culture Collection Time: 7/1/18 at 1800

IV antibiotic at 7/1/18 at 2100

Severe Sepsis Presentation Time is 7/2/18 at 0900

Timeframe for Blood Culture Collection:

6/30/18 at 2100 through 7/2/18 at 1200.

Blood Culture Collection = value "1" (Yes)

Blood Culture Collection Date = 7/1/18

Blood Culture Collection Time = 1800

Broad Spectrum or Other Antibiotic Administration Selection v5.4

Q: If the physician documents “left leg wound with MRSA starting Vancomycin,” is this documentation acceptable to select value “1” (Yes) if IV Vancomycin is started within 3 hours after the Severe Sepsis Presentation Date and Time?

A: Value “2” (No) should be selected in this case.

Broad Spectrum or Other Antibiotic Administration Selection v5.4

Physician/APN/PA documentation requirements if an IV antibiotic is not from Appendix C Table 5.0 (monotherapy) or Table 5.1 (combination therapy):

- Documentation referencing the results of a culture from within 5 days prior to the antibiotic start time.
- Identify the date of the culture results (must be within 5 days prior to the antibiotic start time).
- Identify the suspected causative organism from the culture result and its antibiotic susceptibility.

Broad Spectrum or Other Antibiotic Administration Selection v5.4

Example:

Physician/APN/PA documentation: “Wound culture results from 7/12/18 show MRSA, with sensitivity to Vancomycin.”

The patient has severe sepsis with criteria met on 7/15/18 at 15:00 and the only antibiotic started is IV Vancomycin on 7/15/18 at 15:30.

Value “1” (Yes) should be selected.

Crystalloid Fluid Administration v5.4

Q: If there is a single order for NS 30 mL/kg over 2 hours and during the 30 mL/kg infusion an IV antibiotic diluted in NS is administered at 150 mL per hour, do we have to include the NS used to dilute the IV antibiotic toward the target ordered volume?

A: Yes, the crystalloid fluids (NS) used to dilute the IV antibiotic should be used toward the target ordered volume of crystalloid fluids.

Crystalloid Fluid Administration v5.4

Q: If two or more crystalloid fluid infusions are running at the same time, how do we calculate the completion time of the target ordered volume?

A: Combine the mL per minute of the infusions running simultaneously to calculate when the target ordered volume was completely infused.

Crystalloid Fluid Administration v5.4

Example:

Physician Order: NS 2000 mL at 1000 mL/hr

Physician Order: Vancomycin 1000 mg/250 mL NS over 60 minutes

MAR:

1. 0800 Started - NS 1000 mL at 1000 mL/hr
2. 0900 Started - Vancomycin 1000 mg/250 mL NS over 60 minutes
3. 0900 Started - NS 1000 mL at 1000 mL/hr

Target Ordered Volume – 2100 mL

Crystalloid Fluid Administration v5.4

Example Continued:

0800 to 0900 – 1000 mL infused

1100 mL still needed for target ordered volume

0900 to 1000 – Infusions #2 and #3 ran simultaneously

Infusion #2 infusing at 16.67 mL per minute

Infusion #3 infusing at 4.2 mL per minute

$16.67 + 4.2 \text{ mL per minute} = 20.87 \text{ mL per minute combined}$

$1100 \text{ mL} \div 20.87 \text{ mL per minute} = 53 \text{ minutes}$

2100 mL completed at 0953

Crystalloid Fluid Administration v5.4

Q: When calculating the target ordered volume, can we use the minimum volume (within 10% lower than the 30mL/kg) as the target volume to determine when the fluids were completely administered?

A: Only crystalloid fluid volumes ordered that are within 10% lower than the 30 mL/kg total volume are acceptable. In addition, only crystalloid fluid orders can be used to determine the target ordered volume. Administering or abstracting less than the ordered amount is not acceptable.

Directive for Comfort Care, Severe Sepsis & Septic Shock v5.4

Q: What if a palliative care consult is ordered within the timeframe but the palliative care team does not see the patient until after the timeframe, can value “1” (Yes) be selected?

A: Yes, the physician/APN/PA order for palliative care consult documented within the specified timeframe would suffice for selecting value “1” (Yes).

Initial Hypotension v5.4

Q: If within the 6 hours before through 6 hours after the Severe Sepsis Presentation Time we have multiple blood pressure readings, but only two BP readings are hypotensive and they are not consecutive, is this considered Initial Hypotension?

A: Value “1” (Yes) should be selected when two hypotensive blood pressures are documented within the timeframe of 6 hours before through 6 hours after the Severe Sepsis Presentation Time. The hypotensive blood pressures do not need to be consecutive.

Initial Hypotension v5.4

Q: If the Severe Sepsis Presentation Time was 1100, hypotensive blood pressures documented at 1000 and 1330, and the target ordered volume of crystalloid fluids completed at 1130, what value should be selected for Initial Hypotension?

A: With the target ordered volume of crystalloid fluids completing prior to the second hypotensive blood pressure, value “2” (No) should be selected for Initial Hypotension.

Initial Hypotension v5.4

Q: If there are two hypotensive BP's within the specified timeframe but no IV fluids were ordered, do you still abstract Initial Hypotension?

A: Yes, Initial Hypotension should be abstracted. If no crystalloid fluids were ordered, value "3" (No) should be selected upon reaching the Crystalloid Fluid Administration data element.

Initial Hypotension Time v5.4

Q: If the following blood pressure readings were documented within the timeframe for Initial Hypotension, which time would determine initial hypotension?

Severe Sepsis Presentation Time 1800

Blood Pressures

1300 – 88/54

1400 – 92/58

1500 – 91/59

1600 – 86/52

1900 – 83/48

2000 – 87/53

A: Initial Hypotension Time = 1600

Persistent Hypotension v5.4

Q: Why is value “3” (No) selected for Persistent Hypotension when multiple blood pressures are documented within the hour and the last two blood pressure readings are a normal BP followed by a hypotensive BP?

A: Value “3” (No) is selected because another blood pressure is needed to determine if hypotension persists or if the blood pressure is normalizing.

Persistent Hypotension v5.4

Example:

Persistent Hypotension assessed 1415 to 1515

Blood Pressures:

1420 – 95/60

1435 – 92/51

1450 – 87/50

Select Value “3” (No)

Repeat Volume Status and Tissue Perfusion Assessment Performed v5.4

Q: Is the following documentation acceptable for physician/APN/PA documentation of attesting to performing the Repeat Volume Status data element?

Form: History & Physical
Section: Exam Findings
Neurologic – A&O x3
HEENT - Negative
Heart – WNL, HR 96
Lungs – Clear bilaterally
Abdomen – Positive BS x4
Skin – WNL

A: No, the documentation of the findings of an exam will not suffice for physician/APN/PA documentation attesting to their performance of an exam. Documentation of the findings of an exam can be used to suffice individual components of the Repeat Volume Status and Tissue Perfusion Assessment Performed data element (e.g. skin, capillary refill, cardiopulmonary assessment).

Repeat Volume Status and Tissue Perfusion Assessment Performed v5.4

Q: The first option indicates physician/APN/PA documentation attesting to performing or completing a sepsis focused exam is acceptable. Is the focused exam still required for meeting the requirements of the repeat volume status and tissue perfusion assessment?

A: No. The focused exam requirement from previous versions has been integrated into this new data element. This data element provides three options considered acceptable.

The first option includes different terms or phrases considered synonymous with documentation of completing a physical exam of the patient. Therefore, if “Sepsis focused exam” is included on a clinician form or a physician/APN/PA documents they completed a focused exam, it is acceptable to meet the intent of the data element.

Severe Sepsis Present v5.4

Q: If prior to or within 24 hours after the Severe Sepsis Presentation Time the physician noted "thrombocytopenia related to chronic hepatitis C," could we exclude all platelet values for organ dysfunction?

A: All low platelet values would be excluded due to the physician documentation that includes the general reference to low platelet count (thrombocytopenia) and the documentation of the chronic condition.

Severe Sepsis Present v5.4

Q: If prior to or within 24 hours after the Severe Sepsis Presentation Time the physician noted “platelets 75 related to chronic hepatitis C,” could we exclude all platelet values for organ dysfunction?

A: Only the platelet count of 75 would not be excluded due to the physician documentation that includes this specific platelet count and the documentation of the chronic condition.

Severe Sepsis Present v5.4

Q: If the PA documents “elevated lactate due to seizure,” should the elevated lactate be used or not used for evidence of organ dysfunction?

A: The sign of organ dysfunction documented as due to an acute condition **should be used**.

To exclude the sign of organ dysfunction, further physician/APN/PA documentation stating the acute condition is due to a non-infectious source is required.

Example:

“seizures related to ETOH withdrawal”

Severe Sepsis Present v5.4

Q: Within the H&P, Xarelto is listed under the Home Medications section. Should the elevated INR be used for a sign of organ dysfunction?

A: With an anticoagulant from Table 5.3 documented in the Home Medications section or documented as given on the hospital MAR, the elevated INR **should not be used.**

Severe Sepsis Present v5.4

Q: Which physician documentation is acceptable to disregard tachycardia when A-fib is documented?

1. "A-fib with RVR"
2. "A-fib with tachycardia"
3. "Chronic A-fib, now presenting with RVR"
4. "History of A-fib," "A-fib with tachycardia"

A: For the physician documentation within the specified timeframe:

1. Use elevated heart rates since A-fib is not documented as a chronic condition.
2. Use elevated heart rates since A-fib is not documented as a chronic condition.
3. Do not use the heart rates since A-fib is documented as a chronic condition.
4. Do not use the heart rates since A-fib is documented as a chronic condition.

Severe Sepsis Present v5.4

Q: What allowable value should be abstracted for Severe Sepsis Present with the following physician documentation?

7/15/18 0800: “Severe Sepsis likely due to influenza”

7/16/18 1800: “Patient now with Septic Shock”

A: Select value “1” (Yes) for Severe Sepsis Present based on the documentation of Septic Shock on 7/16/18 at 1800.

Severe Sepsis Present v5.4

Q: How should *Severe Sepsis Present* be abstracted with the following documentation?

7/5/18 0800: Severe Sepsis clinical criteria met (a, b, c)

7/5/18 1200 PA Note: “patient not septic”

7/5/18 1300 MD Note: “transferring to ICU due to Septic Shock”

A: Select value “2” (No) for Severe Sepsis Present based on the documentation “patient not septic” on 7/5/18 at 1200.

Severe Sepsis & Septic Shock Presentation Date & Time v5.4

Q: In the following scenario, which date and time should be abstracted for the Severe Sepsis Presentation Date and Time?

7/1/18 1930 - Arrival to ED

7/1/18 2300 - ED physician Note: “Severe Sepsis present on admission”

7/1/18 2315 - Order for Admission to ICU

7/1/18 2320 - Status changed to inpatient

7/2/18 0330 – RN Note: Patient arrived to ICU Rm. 4

A: Abstract 7/2/18 at 0330 for the Severe Sepsis Presentation Date and Time.

SEP-1 Early Management Bundle, Severe Sepsis/Septic Shock: Providence Tarzana Medical Center's Sepsis Journey and v5.4 Frequently Asked Questions

Questions

Continuing Education Approval

This program has been pre-approved for 1.5 continuing education (CE) unit for the following professional boards:

- **National**

- Board of Registered Nursing (Provider #16578)

- **Florida**

- Board of Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling
- Board of Nursing Home Administrators
- Board of Dietetics and Nutrition Practice Council
- Board of Pharmacy

Note: To verify CE approval for any other state, license or certification, please check with your licensing or certification board.

CE Credit Process

- Complete the ReadyTalk® survey that will pop up after the webinar, or wait for the survey that will be sent to all registrants within the next 48 hours.
- After completion of the survey, click “Done” at the bottom of the screen.
- Another page will open that asks you to register in the HSAG Learning Management Center.
 - This is a separate registration from ReadyTalk®.
 - Please use your **personal** email so you can receive your certificate.
 - Healthcare facilities have firewalls up that block our certificates.

CE Certificate Problems

- If you do not **immediately** receive a response to the email that you signed up with in the Learning Management Center, you have a firewall up that is blocking the link that was sent.
- Please go back to the **New User** link and register your personal email account.
 - Personal emails do not have firewalls.

CE Credit Process: Survey

No

Please provide any additional comments

10. What is your overall level of satisfaction with this presentation?

Very satisfied

Somewhat satisfied

Neutral

Somewhat dissatisfied

Very dissatisfied

If you answered "very dissatisfied", please explain

11. What topics would be of interest to you for future presentations?

12. If you have questions or concerns, please feel free to leave your name and phone number or email address and we will contact you.

Done

Powered by [SurveyMonkey](#)
Check out our [sample surveys](#) and create your own now!

CE Credit Process: Certificate

Thank you for completing our survey!

Please click on one of the links below to obtain your certificate for your state licensure.

You must be registered with the learning management site.

New User Link:
<https://lmc.hshapps.com/register/default.aspx?ID=da0a12bc-db39-408f-b429-d6f6b9ccb1ae>

Existing User Link:
<https://lmc.hshapps.com/test/adduser.aspx?ID=da0a12bc-db39-408f-b429-d6f6b9ccb1ae>

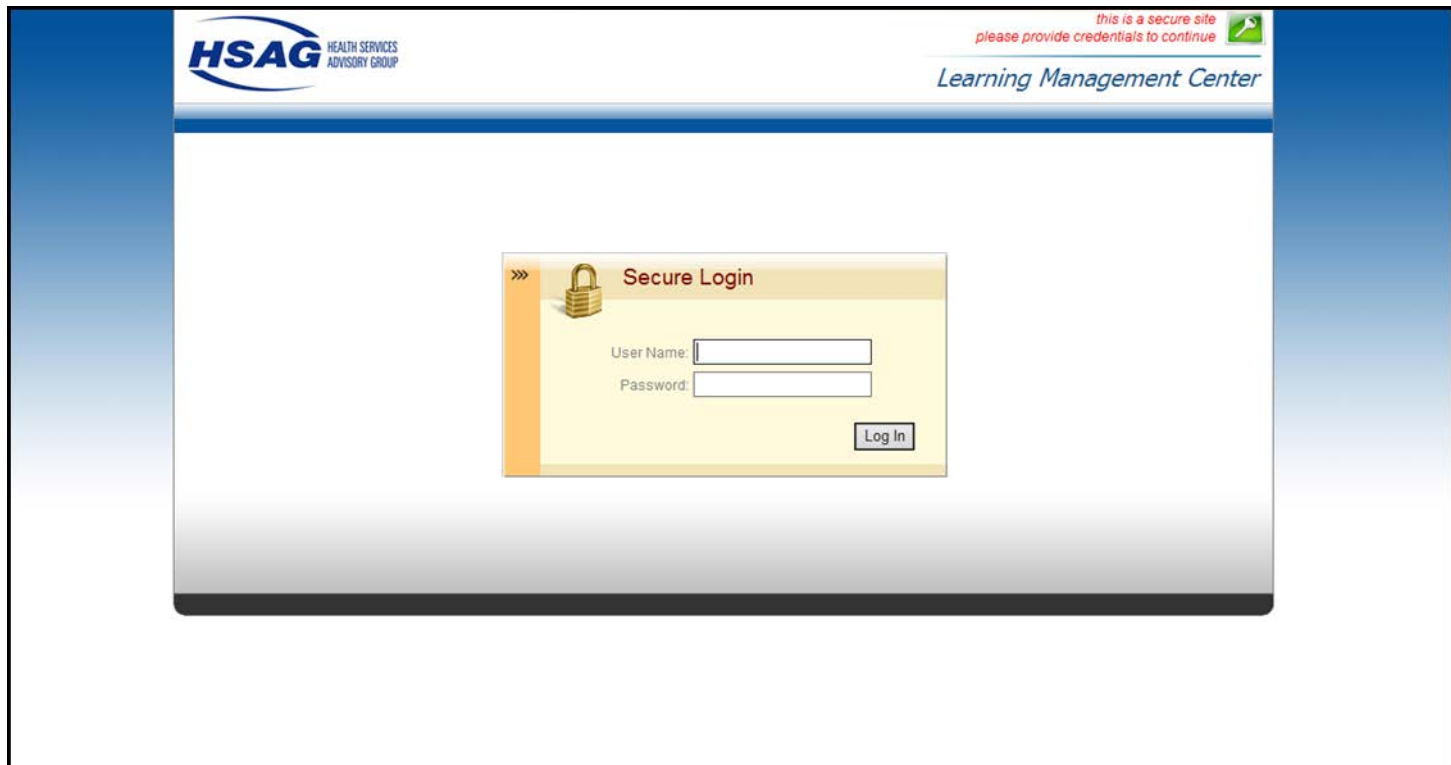
Note: If you click the 'Done' button below, you will not have the opportunity to receive your certificate without participating in a longer survey.

Done

CE Credit Process: New User

The screenshot shows a web browser window displaying the registration page for a new user. The page header includes the HSAG logo (Health Services Advisory Group) on the left and a security notice on the right: "this is a secure site please provide credentials to continue" with a lock icon. Below the header, the text "Learning Management Center" is displayed. The main content area is titled "Learning Center Registration: OQR: 2015 Specifications Manual Update - 1-21-2015". The registration form contains four input fields: "First Name:", "Last Name:", "Email:", and "Phone:". The "Phone:" field has a small icon of a telephone handset. Below the input fields is a "Register" button. The entire form is set against a light blue gradient background.

CE Credit Process: Existing User



The screenshot displays the login interface for the HSAG Learning Management Center. At the top left is the HSAG logo (Health Services Advisory Group). At the top right, a security notice reads "this is a secure site please provide credentials to continue" with a lock icon. Below this is the text "Learning Management Center". The central focus is a "Secure Login" box containing a padlock icon, a "User Name:" label with an input field, a "Password:" label with an input field, and a "Log In" button.

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