

Guidance and responses were provided based on information known on 8/9/2023 and may become out of date. Guidance is being updated rapidly; users should look to CDC and NE DHHS guidance for updates.

Infection Prevention Updates for Acute Care and Outpatient Settings

August 9, 2023



NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Presenters & Questions and Answer Session

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Please use the Q&A box in the webinar platform to type a question to be read aloud. If your question is not answered during the webinar, please e-mail it to nebraskaicap@nebraskamed.com or call Monday – Friday 8:00 am – 4:00 pm CST to speak with one of our Infection Preventionists.

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No conflicts of interest were identified for any member of the planning committee, presenters or panelists of the program content

This CE is hosted by Nebraska Medicine and UNMC along with Nebraska ICAP and Nebraska DHHS



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Diagnostic Stewardship Strategies: Reducing Testing for and Treatment of Asymptomatic Bacteriuria

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University of Nebraska
Medical Center



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Learning Objectives



Explain the concept of diagnostic stewardship and its importance for reducing the treatment of asymptomatic bacteriuria.



Identify strategies for decreasing unnecessary urine culture ordering.



Identify strategies for diagnostic stewardship during urine culture processing.



Review opportunities to decrease treatment of ASB through reporting strategies.

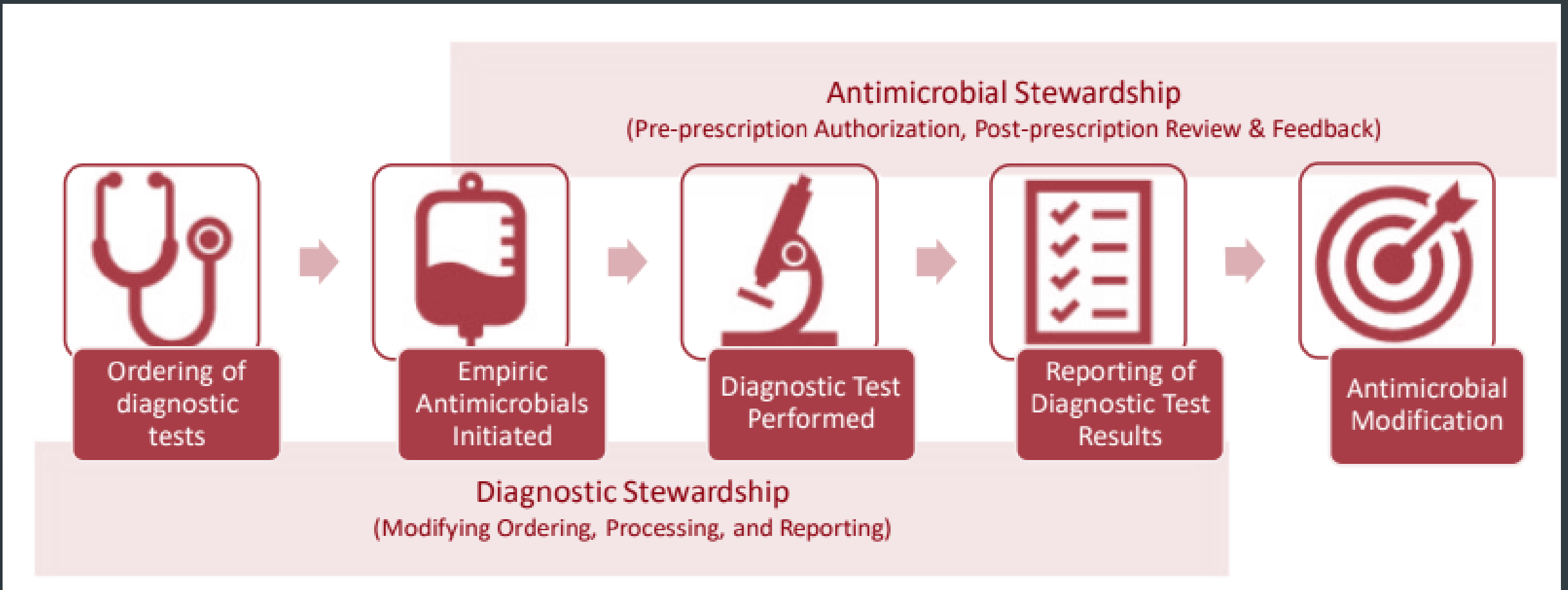


Objective 1: Explain the concept of diagnostic stewardship and its importance for reducing the treatment of asymptomatic bacteriuria



We Need Diagnostic Stewardship!

Diagnostic stewardship refers to the appropriate use of laboratory testing to guide patient management, including treatment, in order to optimize clinical outcomes and limit the spread of antimicrobial resistance.





Advantages of Urine Culture Stewardship

Institutions that have implemented urine culture stewardship have reported decreases in:

- Number of total urine cultures ordered
- Number of ASB cases treated inappropriately
- Costs related to overtreatment of ASB
- CAUTIs



With no increases in patient adverse events.

Opportunity for collaboration between phases of healthcare.



Asymptomatic Bacteriuria (ASB)



Presence of bacteria in the urine in the absence of urinary tract signs and symptoms

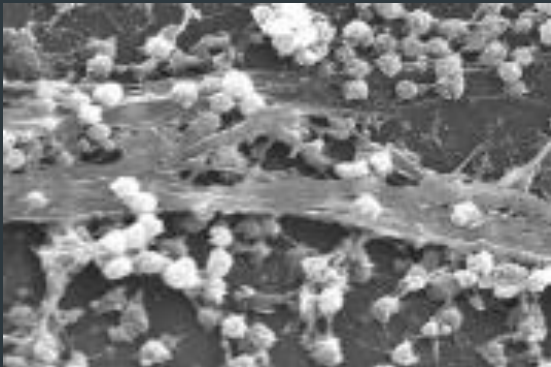
Incidence

- 5-15% in healthy individuals
- 30-60% in elderly LTC residents
- 100% in chronic urinary catheters



Up to 50% of cases receive antibiotics!

Increased cost, side effects, and antimicrobial resistance with no impact on survival



S. aureus biofilm on the surface of an indwelling catheter. Credit: [CDC Public Health Image Library \(PHIL\)](#)



Asymptomatic Bacteriuria (ASB)



Reasons for treatment

Overcautiousness/Risk Perceptions
Overworked
Institutional culture/Social norms

Trautner BW, Petersen NJ, Hysong SJ, Horwitz D, Kelly PA, Naik AD. Overtreatment of asymptomatic bacteriuria: identifying provider barriers to evidence-based care. *Am J Infect Control.* 2014;42(6):653–658.



Survey of 551 primary care clinicians in 2022: 71% would prescribe antibiotics without a clear symptom indication if cultures grew bacteria

Baghdadi JD, Korenstein D, Pineles L, et al. Exploration of primary care clinician attitudes and cognitive characteristics associated with prescribing antibiotics for asymptomatic bacteriuria. *JAMA Netw Open.* 2022;5(5):e2214268.



Survey of 95 Hospital resident physicians - Only 33% could differentiate ASB from true infection - After correct identification, 50% still prescribed antibiotics

Lee MJ, Kim M, Kim NH, et al. Why is asymptomatic bacteriuria overtreated?: a tertiary care institutional survey of resident physicians. *BMC Infect Dis.* 2015;15:289.



Clinical inertia – if started in the ED, continued for at least 3 days

Longer hospitalization
Development of CDI

Eyer MM, Läng M, Aujesky D, Marschall J. Overtreatment of asymptomatic bacteriuria: a qualitative study. *J Hosp Infect.* 2016;93(3):297–303.

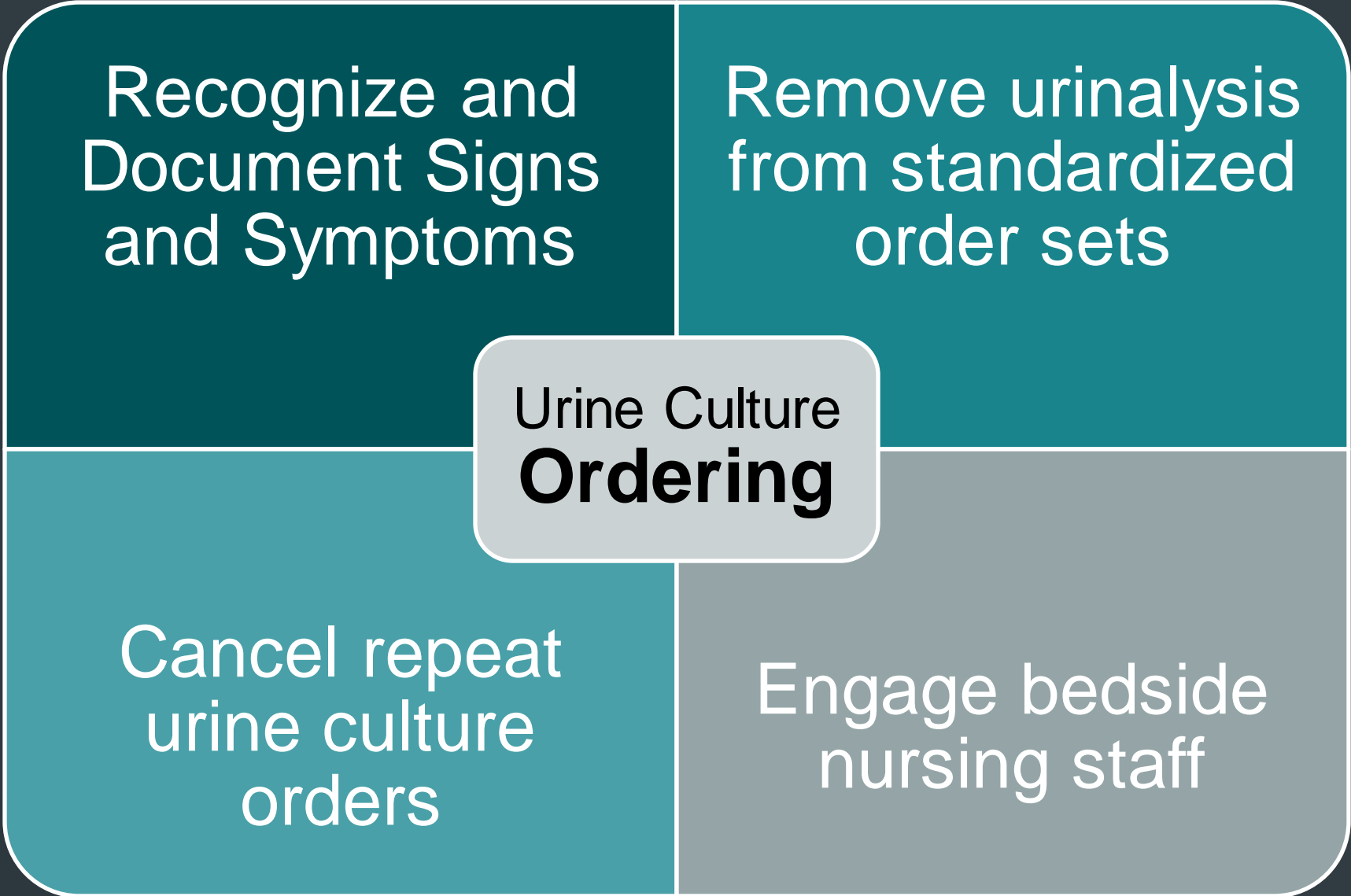
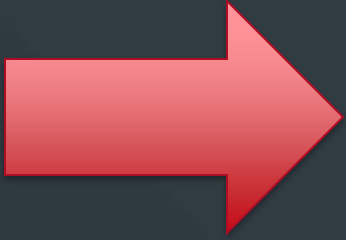


Cost Implications

- In 2019, >36 million hospitalizations in the US
 - 27% of hospitalizations are associated with a urine culture
 - At about \$10 per culture (Medicare clinical laboratory fee schedule CPT code 87086), this translates to almost \$100 million annually in the inpatient setting alone
- These data, coupled with the large quantity of urine cultures obtained in the emergency, ambulatory, and long-term care settings, underscore the opportunity for cost avoidance
- Further cost savings would be associated with the reduction in treatment of asymptomatic bacteriuria



Objective 2: Identify strategies for decreasing unnecessary urine culture ordering





Recognize and DOCUMENT urinary tract infection signs and symptoms

Patients without Urinary Catheters

Appropriate

Dysuria, suprapubic pain, flank pain, Costovertebral angle (CVA) tenderness, or septic shock

Uncertain

Fever or systemic leukocytosis with no other known cause

Inappropriate

Altered mental status, or change in urine characteristics (color, sediment, smell)

Patients with Urinary Catheters

Appropriate

Dysuria, suprapubic pain flank pain, Costovertebral angle (CVA) tenderness, or septic shock

Uncertain

Fever, systemic leukocytosis with no other known cause, or delirium*

Inappropriate

Change in urine characteristics (color, sediment, smell)

*Delirium as defined by validated tool such as the Confusion Assessment Method. Urinary catheter broadly defined to include both internal and external catheter use.



SHEA Guidance on non-localizing signs and symptoms in LTC Residents

Debilitated patients with nonspecific symptoms are a challenge – ASB is common, as are nonspecific symptoms. Use caution in ordering and interpreting cultures in this population – risk of overdiagnosis is high given rates of ASB!

Further Evaluate for Infection:

- Fever
- Hypothermia
- Hypotension
- Hyperglycemia
- Delirium

No further evaluation for infection:

- Behavior changes exclusive of delirium
- Functional decline
- Falls
- Anorexia



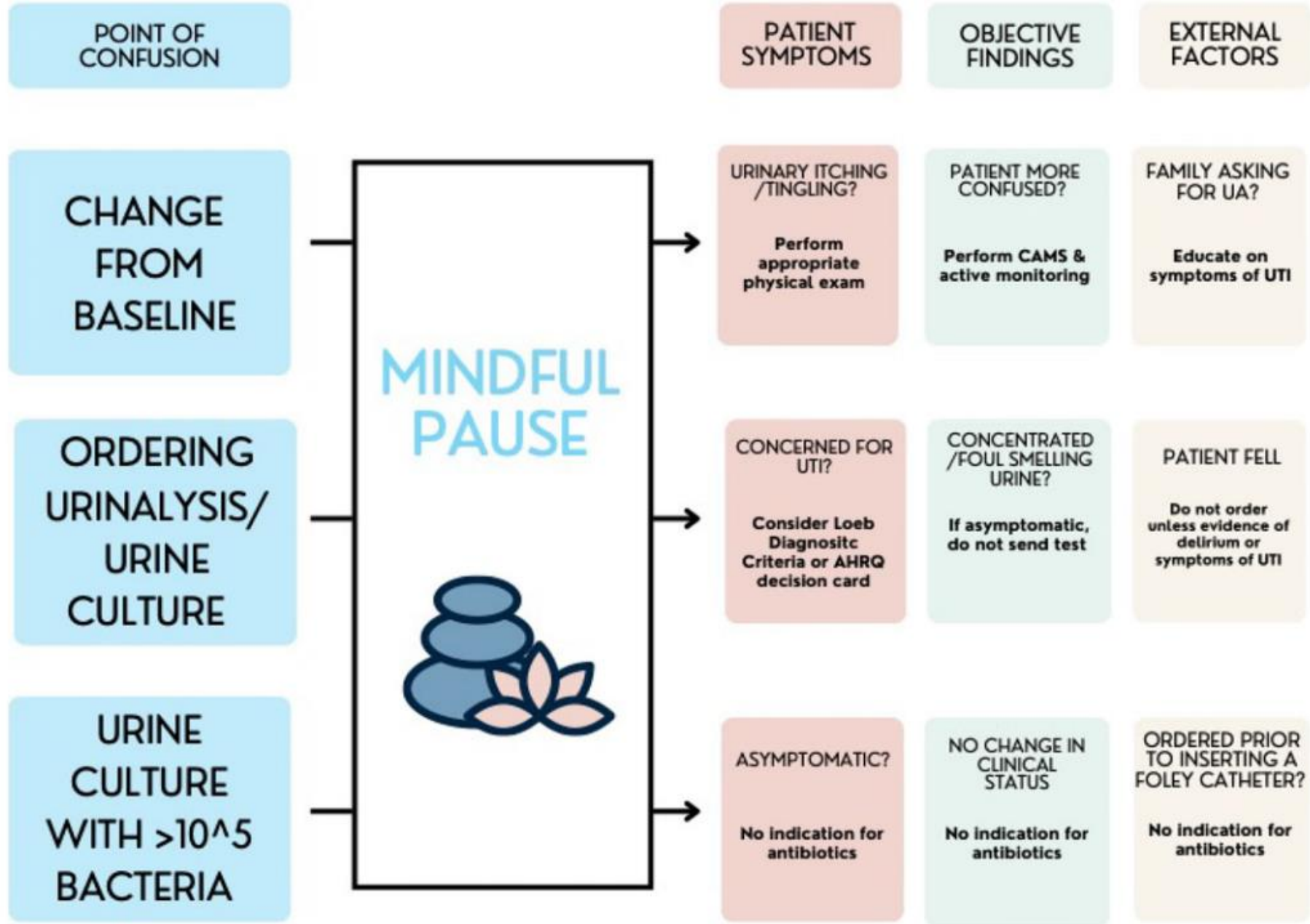
Special Populations/Clinical Situations Excluded from the Consensus Panel

- Children under 3 years of age
- Pregnancy
- Kidney transplant within 1 year
- Neutropenic patients
- Altered urinary tract anatomy
- Recent GU procedure (within 30 days)
- Preop GU procedure
- ≥ 2 SIRS criteria
- Documented additional bacterial infection
- Imaging suggestive of cystitis/pyelonephritis

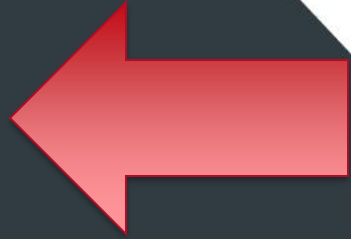
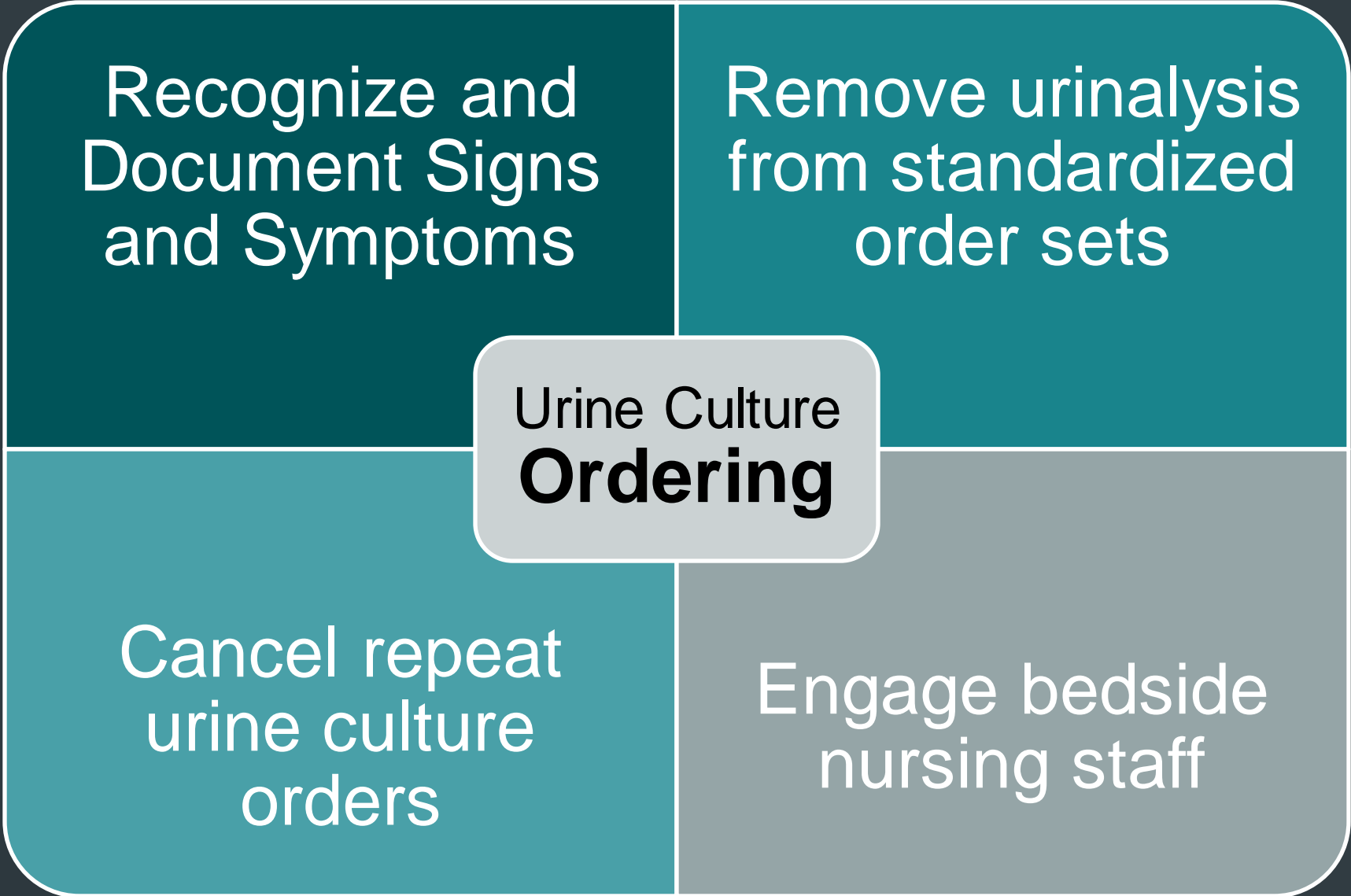


Require Indication on Urine Culture Orders

- The current recommendation is that the clinician be prompted to document signs and symptoms of infection when requesting a urine culture.
- The assignment of a symptom complex to a culture is designed to reduce testing in the absence of UTI symptoms and, thus, to subsequently reduce unnecessary treatment of asymptomatic bacteriuria.
- Opportunity for Education and Feedback
 - Providing an individual physician with feedback on lack of documentation of reasons for ordering urine cultures
 - Presenting aggregate findings at monthly committee meetings regarding how frequently the reason for ordering urine culture was not documented.
 - Identifying how often the reason for the urine culture being ordered can be classified as appropriate or inappropriate. A written report can be sent to each provider along with education materials on the appropriate reasons for urine culture



Amenta E, Jump R, Trautner B. Bacteriuria in older adults triggers confusion in healthcare providers: A mindful pause to treat the worry. ASHE (2023), 3, e4, 1-4





Remove UA/Urine Culture Orders From Standard Clinical Order Sets

Emergency department evaluation

Hospital admission

Inpatient pre-op

Assessment of altered mental status

Assessment of falls in long-term care



Remove UA orders from Emergency Room order sets



One study from 2020 found that 74.4% of patients with ASB in the ED are treated with antibiotics.



Predictors of treatment of ASB versus no treatment included dementia, spinal cord injury, urinary catheter, altered mental status, leukocytosis, and abnormal urinalysis



Treatment of these patients with antibiotics was associated with significantly increased adverse event rates, hospital length of stay, and *C. difficile* infections.



Nebraska Medicine UA Order Set Data

April 1, 2022 – June 30, 2022

Order Set Name	Count
NM ED QUICKLIST TRIAGE PROTOCOL ORDER PANELS	1232
ED TRAUMA TREATMENT - GREATER THAN 12 Y/O	130
ED ISCHEMIC STROKE PROTOCOL	33
NMC ED ABDOMINAL PAIN QUICK LIST	30
NMC ED OD/PSYCH QUICKLIST	25
NMC ED CHEST PAIN QUICK LIST	19
NMC ED VAGINAL BLEEDING QUICK LIST	10
ED ABDOMINAL PAIN TREATMENT	7
NMC ED TRAUMA QUICK LIST	7
ED CHIEF COMPLAINT: MINOR MVC	4
NM SEXUAL ASSAULT TREATMENT	4
ED TRAUMA TREATMENT 12 Y/O OR YOUNGER	3
NEU FOCUSED GENERAL NEUROLOGY	2
NEU NEUROLOGY GENERAL ADMISSION	1

Study completed by: Olivia Collins, PharmD, PGY2 EM Resident



Nebraska Medicine MUE Study

Design: Medication use evaluation from April 1, 2022 through June 30, 2022

Patients: Patients encounters were identified if they were charged for a urinalysis (UA) and subsequently discharged from the ED

Randomization: Each encounter was assigned a random number and sorted in numeric order, then encounters were randomly selected for review of ASB

Primary Outcome: Incidence of antibiotic prescribing on **discharge** for patients with ASB



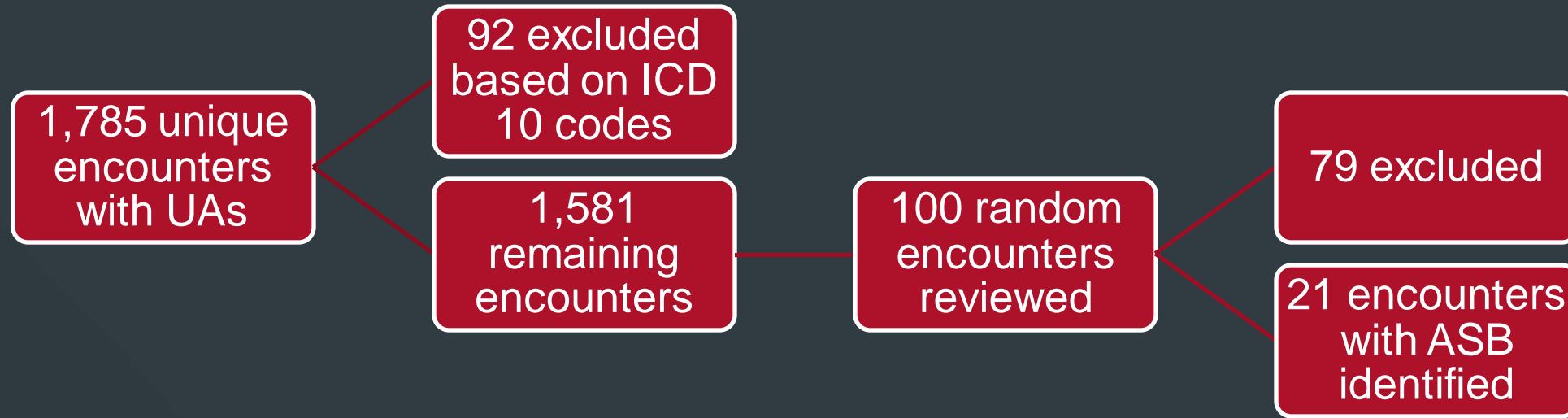
Inclusion/Exclusion Criteria

Inclusion Criteria

- Age > 18
- Met study definition for ASB

Exclusion Criteria

- Altered urinary tract anatomy
- Pregnant
- GU procedure within 30 days
- Transplant within 1 year
- ≥ 2 SIRS criteria
- Documented additional bacterial infection
- Receiving treatment or prophylaxis for urinary tract infection at time of UA
- Imaging suggestive of cystitis/pyelonephritis
- Admitted to an inpatient unit



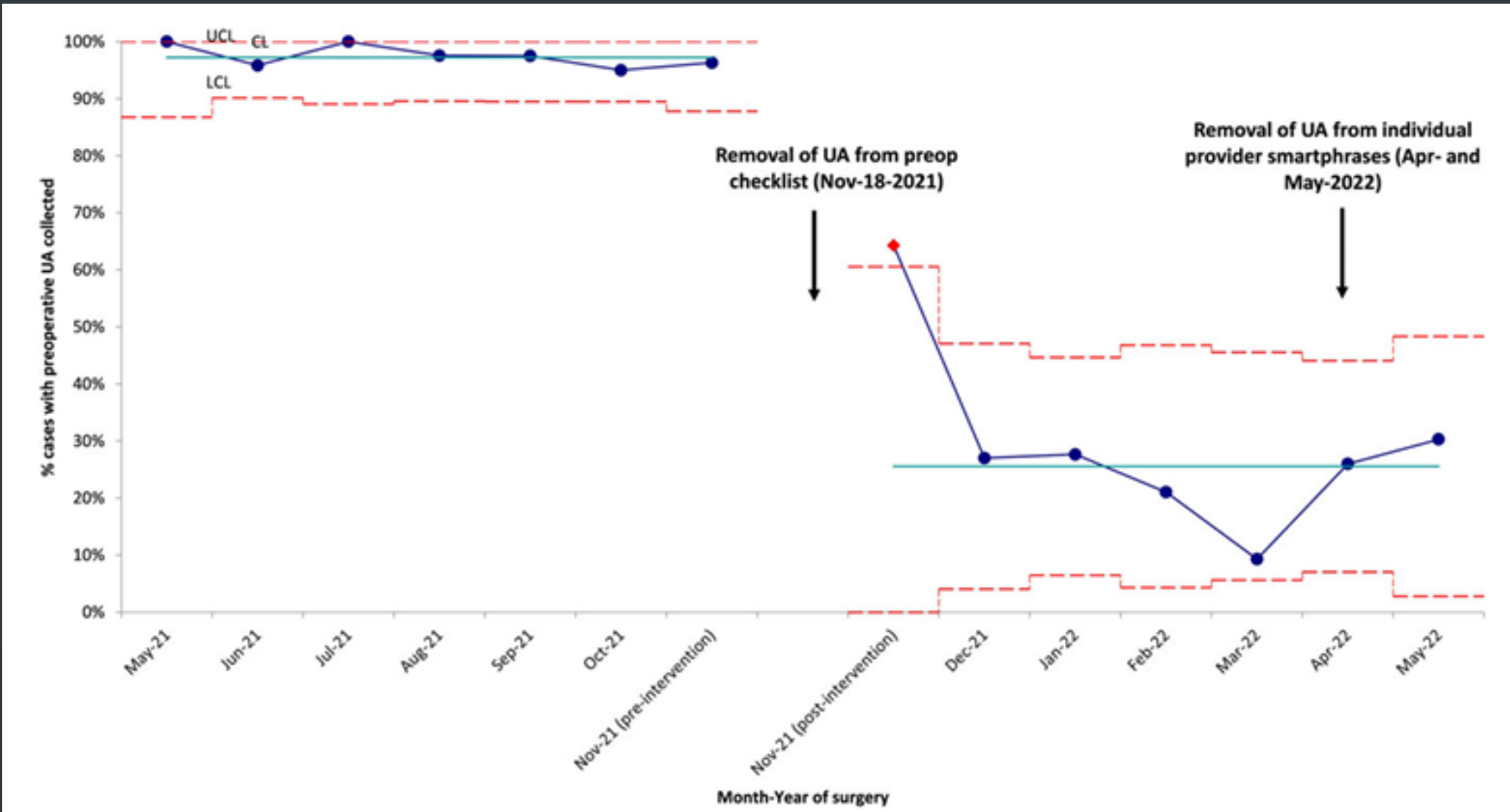


An estimated 24% of patients are treated for ASB on discharge from the NMC ED

This can be extrapolated to 318 discharged patients per year treated for ASB

A majority of these are based off UAs obtained from general triage or ED order sets

Remove UA orders from non-urologic preoperative order sets





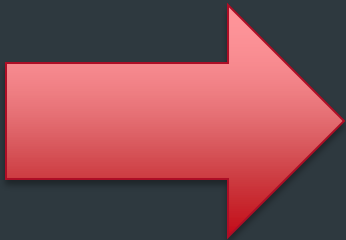
Recognize and Document Signs and Symptoms

Remove urinalysis from standardized order sets

Urine Culture **Ordering**




Cancel repeat urine culture orders

Engage bedside nursing staff





Automatically Cancel Repeat Urine Cultures

-  Consensus guidelines recommend to automatically cancel repeat urine cultures within 5 days of a positive culture during the same hospital admission
-  Consensus guidelines recommend to automatically cancel repeat urine cultures within 7 days for long-term care residents
-  Recommend creating an alert to providers in EHR that a repeat culture has been ordered



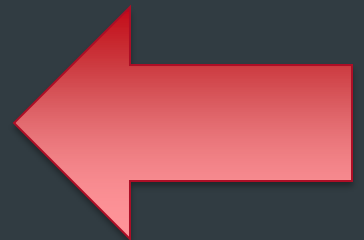
Recognize and Document Signs and Symptoms

Remove urinalysis from standardized order sets

Urine Culture
Ordering

Cancel repeat urine culture orders

Engage frontline nursing staff



Frontline Nursing Engagement

- Complete Checklist
- Discuss with ordering provider
- If order not appropriate escalated to Unit supervisor or IP team
- Review appropriateness of order
- If there are questions, then reach back to ordering provider to discuss patient care



Urine Culture Checklist

Patient Sticker

Admit Date: _____
Specimen Date: _____

Urine Cultures and Urine with Culture, if Indicated

Patient Has Urinary Catheter in place currently or removed in the past day
AND any of the following s/s:

Step 1: Assess for the following symptoms, if present may be appropriate.

- Fever >100.4 Suprapubic tenderness
 Costovertebral tenderness (flank pain) Lower abdominal pain

*If the only symptom(s) the patient is having is/are **burning with urination** or **urinary hesitancy** and the catheter was removed that day or the previous day, attempt to push fluids and delay culture for 24 hours to see if symptoms resolve. If needed, a straight cath is recommended for emptying the bladder.*

A culture is NOT indicated if the only urinary symptom present is one of the following:



- Cloudy urine Sediment
 Strong or foul odor Pan culturing-not recommended (culturing multiple sources without a clear indication of fever source)

Step 2: Resident/Fellows: Contact Attending for validation before ordering.

Nursing: Contact the Charge Nurse, Manager or IP.

Infection Prevention: Angel 402-398-6877 or Becky 402-398-6357 Date/Time _____

Test appropriate? No Yes

Step 3 - If appropriate, collect and send specimen.

Replace Foley before collecting if in place > 72 hours, this includes Chronic Foleys

Step 3 - If inappropriate, discuss and recommend the order be canceled.

Name of provider: _____

Date/Time: _____

Response: _____

If the Provider wants to proceed with testing of an inappropriate specimen >3 days after admission & >2 days after Foley placed, or within a day after Foley removed, contact Infection Prevention Monday- Friday from 8-4:30

Name of staff member completing form: _____ Date/Time _____

Name of Leader verifying appropriateness: _____ Date/Time _____

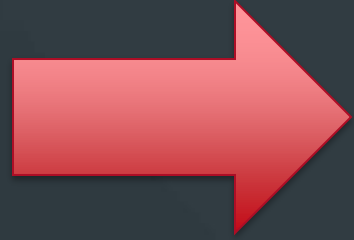


COMPLETED CHECKLIST MUST BE FAXED TO INFECTION PREVENTION AT 402-398-5838

NOT PART OF THE MEDICAL RECORD
2/8/23



Objective 3: Identify strategies for diagnostic stewardship during urine culture processing



Require
Documentation of
Proper Collection

Ensure Proper
Specimen
Handling

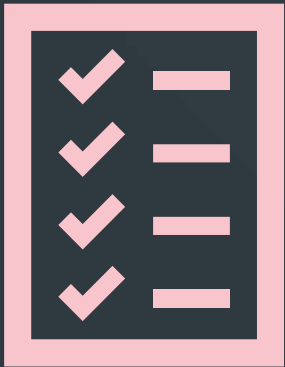
Urine Culture
Processing

Conditional
Reflex Testing

Limit
Contamination
Workup



Require Documentation of Proper Collection



The specimen collection method should be documented before processing cultures

- Midstream Clean Catch
- Indwelling Catheter
- In-and-Out Straight Catheterization



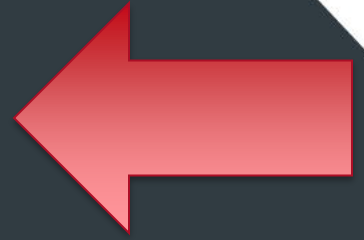
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Ensure Proper Specimen Handling/Management

- Specimens should be collected, stored, and processed in a manner to best prevent contamination with microorganisms, ensure staff is trained!
- The IDSA/ASM guide states that urine should be placed in boric acid (“gray-top”) preservative tubes if transported at room temperature (i.e. to a regional laboratory).
- Alternatively, urine can be refrigerated after collection and during transport, or urine can be inoculated within 30 minutes of collection if not refrigerated and not preserved with boric acid.
- Ensure the appropriate equipment is in stock and easily accessible by staff.
 - Kits contain the equipment needed
 - Step-by-step instructions on appropriately collecting urine cultures
 - Including for the patient if self-collecting
- Quality improvement metric: Average time from collection of culture to arrival in laboratory





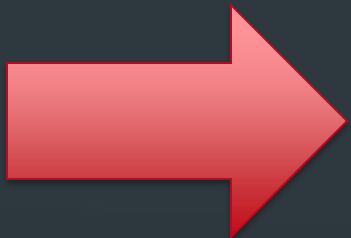
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Conditional Reflex Testing

- Replace stand-alone urine culture orders with conditional reflex urine cultures (urine cultures performed only after specific urinalysis criteria are met)
 - Consensus statement did not define specific criteria (i.e. leukocyte esterase, urine nitrate, WBC >10 vs. >50) so your facility would need to set your own criteria
 - Potential to decrease inappropriate antimicrobial use from 45% to 9%
 - Emergency department study: decrease in inappropriate treatment of ASB from 10.2% to 1.9%
- **The counterpart to this, automatically ordering urine cultures based on abnormal results of routine urinalysis when urine culture was not specifically ordered by the clinician, was deemed highly inappropriate.**



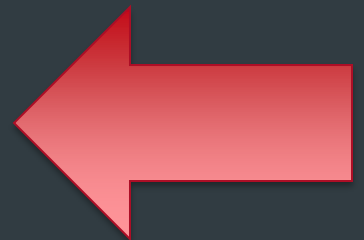
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Contaminated Collections

- Complicate diagnosis of UTI – Often grow multiple organisms
- Significant additional workload for lab
- Increased costs of recollection
- Can result in identification and reporting of organisms that are not responsible for the patient's symptoms
- **Consensus guidelines recommend not routinely working up isolates when more than 2 types of bacteria are recovered from culture**
- **Quality improvement metric: Percent of urine cultures reported as contaminated**



Objective 4: Review opportunities to decrease treatment of ASB through reporting



Include Notes on
the UA and Culture
Reports in the EHR

Clearly define
isolate as pathogen
vs. contamination

Urine Culture
Reporting

Use antibiotic
cascade reporting

Provider
Documentation



Optimizing Lab Reporting

- Behavioral interventions through notes on the culture reports guide prescribers while retaining autonomy
- Inform clinicians that even high colony counts (i.e. $>100,000$ CFU/mL) may not represent true infection in the absence of urinary signs or symptoms
 - “Nudge” prescribers not to treat ASB or mixed growth (contamination)





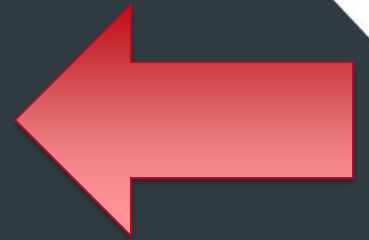
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Documentation





Pathogen vs. Contamination

- Presence of squamous epithelial cells on UA microscopic in a clean catch indicate contamination
 - Not always present, but if present suggest that bacteria could be from skin/genital area rather than bladder
- Consensus guidelines recommend not routinely working up isolates when more than 2 types of bacteria are recovered from culture

Microbiology reports should clearly define isolates as uropathogens vs. skin contaminants



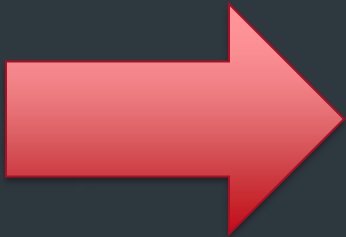
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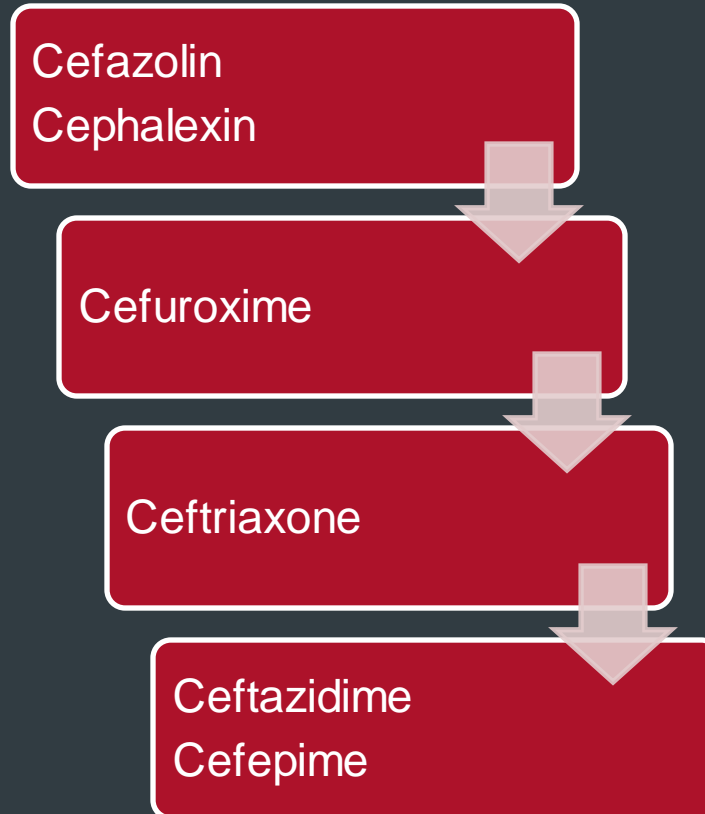




Antibiotic Cascade Reporting

- Report antibiotics from narrowest to broadest spectrum, only revealing a broader susceptibility when a narrower antibiotic is reported as resistant
- **Make sure all known antibiotic susceptibilities are included when compiling hospital antibiogram data**

Cascade Reporting Example for Cephalosporins for Enterobacterales





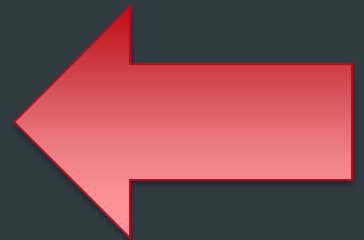
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Epic Dot Phrase



New Dot Phrase for Asymptomatic Bacteriuria (ASB)

WHY?

ASB treatment does NOT improve patient outcomes

ASB treatment is harmful

Important target for improvement



[QR Link to ASB Educational Video](#)

HENRY FORD HEALTH

For asymptomatic patients WITHOUT an indication to treat, document ASB using smart phrase .UANOTTREAT

My Note

Tag Share w/ Patient

Insert SmartText

The patient's UA or culture is positive, but they are asymptomatic. (Asymptomatic = no symptoms or signs of cystitis or pyelonephritis; or new onset mental status changes without 2 or more SIRS criteria). The test results likely represent **asymptomatic bacteriuria**. National and local antibiotic stewardship guidelines recommend no antibiotic treatment. Unnecessary antibiotic treatment carries a risk of adverse effects (e.g. allergic reaction, Clostridioides difficile infection, resistant bacteria) with no benefit to the patient.

Exceptions to no antibiotics for ASB = pregnant women and urologic procedure with mucosal barrier injury



Active Monitoring

For LTC residents who do not meet clinical criteria for UTI (and do not have warning signs), but for whom clinical concern for UTI still exists, respond to this situation of diagnostic uncertainty with 'active monitoring' protocol."

Active monitoring includes:

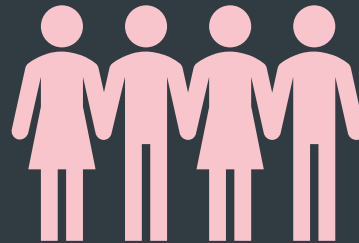
- Frequent assessment of vital signs for early detection of sepsis,
- Assessment for hydration/keeping resident hydrated
- Criteria for notifying the physician or other provider if resident's condition worsen.

- Obtain vital signs (BP, Pulse, Resp Rate, Temp, Pulse Ox) every ____ hours for ____ days.
- Record fluid intake each shift for ____ days.
- Notify physician if fluid intake is less than ____ cc daily.
- Offer resident ____ ounces of water / juice every ____ hours.
- Notify physician, NP, or PA if condition worsens, or if no improvement in ____ hours.
- Obtain the following blood work _____ .
- Consult pharmacist to review medication regimen.
- Contact the physician, NP, PA with an update on the resident's condition on _____.



Considerations for Implementing Urine Culture Diagnostic Stewardship

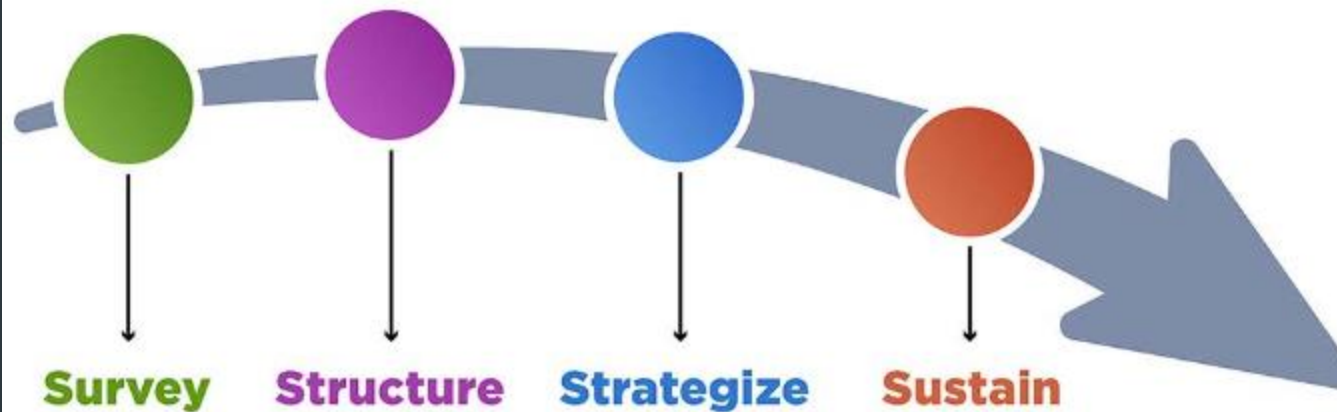
- Include multidisciplinary groups in planning
 - Lack of consensus
 - Variability between labs in specimen handling/processing
- Engage physician champions
 - Understand local culture
- Involve administrative support/health information technology
- Broaden responsibility to individual prescribers





Summary – Developing a Urine Culture Stewardship Program

- **Survey**
current practices and outcomes to determine the potential benefit of urine culture stewardship for your institution.
- **Structure**
your program for success.
- **Strategize**
initiatives you can incorporate into your program
- **Sustain**
reductions achieved with your program.



[Overview |](#)
[Urine Culture](#)
[Stewardship |](#)
[HAI | CDC](#)



Summary – Urine Culture Diagnostic Stewardship

- Can reduce unnecessary orders and decrease cost
- Decreases unnecessary antibiotic use
- Creates a collaborative culture
- Increase patient safety and outcomes

Ultimately the most important determinant of accuracy of urine cultures is patient selection!



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University of Nebraska Medical Center**

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**Post-Graduate Year 2 Emergency Medicine
Pharmacy Resident
Nebraska Medicine**

CHI Infection Control Team

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University of Nebraska
Medical Center



Nebraska
Medicine

Does your facility have questions about the NHSN Antibiotic Use and Resistance (AUR) Module?

Nebraska ASAP Pharmacists are here to help!

To schedule a Q&A meeting about AUR,

Call 402-552-2881

Office Hours are Monday – Friday

8:00 AM - 4:00 PM Central Time



**Nebraska Antimicrobial Stewardship
Assessment and Promotion Program**

Questions and Answer Session

Please use the QA box in the webinar platform to type a question

Attendees also have the option to upvote other attendee's questions

Questions will be read aloud by the moderator

A recording of the discussion will be made available on the Nebraska ICAP website
<https://icap.nebraskamed.com/events/webinar-archive/>

Speakers/ Panelists:

Jenna Preusker, PharmD, BCPS, BCIDP

M. Salman Ashraf, MBBS, FIDSA

Daniel Brailita, MD

Juan Teran Plasencia, MD

Rebecca Martinez, BA, BSN, RN, CIC

Jody Scebold, EdD, MSN, RN, CIC

Chris Cashatt, RN, BSN, CIC

Sarah Stream, MPH, CDA, FADAA

Josette McConville, BSN, RN, CIC

Lacey Pavlovsky, MSN, RN, CIC, LTC-CIP

If time does not allow and we are unable to answer your question, please email us at NE ICAP or call 402.552.2881

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Past Webinars and Slides

Acute Care and Outpatient Setting Webinars



NE DHHS Health Alert Network (HAN): Subscribe to Stay Updated

Nebraska Department of Health and Human Services

Health Alert Network

ALERT

July 18, 2023

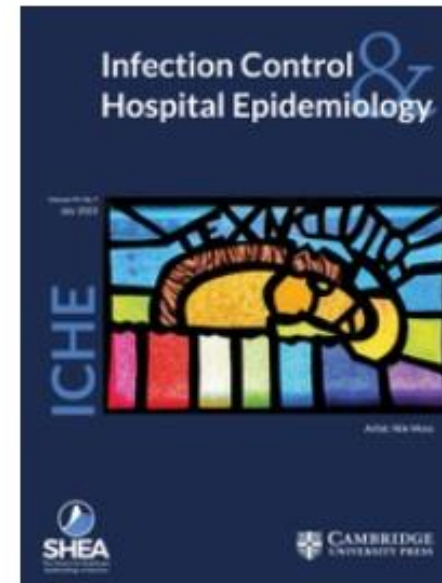
Syphilis Incidence Continues Increasing in Nebraska

- [7/18/23 NE DHHS HAN Alert - Syphilis Increase Continues Increasing in Nebraska](#)
- US incidence of primary and secondary syphilis rates has increased by 700% from 2000-2021
- Since 2017, Nebraska syphilis rates overall have increased 373%; 1163% for females and 1100% for congenital syphilis.
- Review the alert to learn about screening, syphilis stages, treatment, and postexposure prophylaxis.
- [Subscribe for NE DHHS HAN updates](#)



Join Us on Upcoming Webinars

- **September 13, 2023**
 - Strategies to prevent MRSA in acute care hospitals – 2022 SHEA Update
- If you have suggestions for future webinar topics or would like to learn more about a topic one on one, please contact us with your request by calling at 402.552.2881 or email nebraskalCAP@nebraskamed.com. You can also include them in the continuing education (CE) survey.
- You can also be added to our setting specific mailing lists, receive webinar and training invites and be connected to an Infection Preventionist that specializes in your area by filling out the contact form at: <https://icap.nebraskamed.com/contact-us/>



**Infection Control &
Hospital Epidemiology**



Image Courtesy of CDC

SHEA Compendium of
Strategies to Prevent HAIs
2022 Updates





September 15, 2023

UNMC Campus

Morning: Dental Infection Control

Afternoon: Antimicrobial
Stewardship Workshop and
Sterile Technique Workshop

Dental CE offered through UNMC
College of Dentistry

Dental Infection
Control Summit

Register at:

<https://bit.ly/DentalICSummit>

or scan the QR Code →





APIC NEBRASKA

2023 Fall Conference

SPEAKERS

David Cates Ph. D. (Behavioral Health, NMC)

- Resilience Building in Healthcare Settings

Lacey Pavlovsky/Dr. Ashraf (NE DHHS State HAI/AR Program)

- State of the State HAI Report

Kait Chapman (State Extension Office)

- Bed Bugs

Angela Ritchey (Steris)

- Is It Clean? Identifying cleaning tests and establishing quality program for cleaning verification of medical devices

Adam Moench (Phigenics)/Stom Keffer (NE DHHS)

- Water Management Programs

Jodee Sun/Kristi Felix (SJDCLTC), Lacey Pavlovsky (DHHS)

- Panel Discussion: CBIC Long Term Care Infection Control Certification

Nancy Dach (3M)

- Reducing the Risk of Surgical Site Infections: What are we missing?

[REGISTER HERE](#)

DATE: Friday, September 15, 2023

8 a.m.-3:30 p.m. (registration opens at 7 am)

LOCATION: CHI Health St. Elizabeth, Lincoln, NE

COST: \$65 per attendee-lunch included

CEUs: 6 hours applied for through IWCCW

Registration is open to everyone

Social Media



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No on Instagram! Follow us at @nebraskaicap



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Find resources for all facility types at our website: <https://icap.nebraskamed.com/>



ICAP Contact Info

Call 402-552-2881

Office Hours are Monday – Friday

8:00 AM - 4:00 PM Central Time

Weekends and Holidays 8:00-4:00

On-call hours are available for emergencies only



Scan the QR Code to be taken to our website contact form. You can request a call back from an IP, Sign up for newsletters and reminders and request an ICAR Review for your facility.

Webinar CE Process

1 Nursing Contact Hour is awarded by NE Medicine *

* Nebraska Medicine is approved as a provider of nursing continuing professional development by the Midwest Multistate Division, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

CNE Nursing Contact Hours:

- Completion of survey is required.
 - The survey must be specific to the individual obtaining credit.
 - (i.e.: 2 people cannot be listed on the same survey)
- One certificate is issued quarterly for all webinars attended
 - Certificate comes directly from ICAP via email
 - Survey functionality is lost on mobile devices

