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SHEA

Joint Statement

Elevating infection prevention programs

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Since 1986, hospitals have been required to comply with regulations for infection prevention and control (IPC) as a condition of participation from the Centers for Medicare & Medicaid Services (CMS), requirements that have evolved through multiple rulemaking and administrative refinements over time, including expansion to other healthcare facility types. CMS's condition of participation (CoP) for IPC notes the expectation that acute care hospitals " . . . must have active hospital-wide programs for the surveillance, prevention and control of healthcare-associated infections (HAIs) and other infectious diseases, and for the optimization of antibiotic use through stewardship." (42 CFR 482.42.) The interpretative guidance for implementing the CoP provides some parameters for determining what is an "active" IPC program; however, there is significant variability in IPC practice in healthcare facilities across the U.S.

In addition, IPC programs are now threatened with major workforce challenges. With approximately 40% of the infection preventionist workforce eligible to retire within the next 10 years and a shrinking population of physicians who are choosing to specialize in infectious diseases, we are at a critical crossroads where inadequate staffing will not only strain healthcare organization IPC programs, but place patients in harm's way for greater risk of infection.

Under workforce shortage conditions, the definition of an "active" IPC program has the potential to be relegated to the bare minimum of what is required to qualify for CMS CoP. APIC and SHEA believe that striving for what is minimally required under federal regulation is antithetical to our societies' collective goals of reducing preventable harms and improving the quality of care in the U.S. healthcare system. Inadequate staffing and resources also risk efforts to achieve our national goals in the United States to reduce HAIs (https://www.hhs.gov/oidp/topics/health-care-associated-infections/hai-action-plan/index.html) which are part of a larger global effort to prioritize IPC programs to ensure that they are staffed with trained and experienced experts. We cannot advance our collective goals for harm reduction and quality improvement without elevating expectations for IPC programs to strive to be *effective* and not merely "active." Raising this bar can only be achieved through investments that recognize IPC programs adequately supported by qualified teams as foundational to healthcare facility infrastructure.

To this end, APIC and SHEA believe prioritizing and addressing the impending workforce shortage and the purposeful reduction of staffing in IPC programs are imperative. Both societies have several initiatives aimed at growing the IPC workforce. For example, APIC has developed the requisite curriculum for an infection prevention degree and non-degree programs and has worked with the Department of Labor on a new national apprenticeship program. APIC has also developed an IPC Staffing Calculator, a tool which provides evidenced-based recommendations to assist with IPC program staffing decisions. SHEA has increased the number of fellows who attend SHEA's educational efforts and is working with the Infectious Diseases Society of America (IDSA) to address compensation challenges for infectious diseases physicians, specialists who often serve as medical directors or epidemiologists in IPC programs. SHEA is also working to develop career pathways learning that attracts talented physicians to the infectious diseases and infection prevention specialties. These initiatives, combined with investments in IPC infrastructure, will support the forward momentum needed to tackle our workforce shortage challenges.

Prevention is challenging to put a price tag on. It is not easy to conceptualize the total impact of the reduced incidence of harm, including patient and healthcare personnel morbidity and even mortality as well as positive collateral impacts such as reduced waste, costs, and reputational impact. Long-term savings due to preventing disease transmission is often overlooked in favor of short-term budgeting. Yet, infection prevention has broad impact across the healthcare continuum, influencing factors such as the incidence of antibiotic resistance, HAIs, and other infectious safety risks wherever healthcare is delivered. APIC and SHEA will soon be releasing a joint position paper that provides a framework that outlines what is needed for effective healthcare facility IPC programs led by a dyad leadership model that complements and supports the expertise of each clinical specialist leader. Combined with administrative acumen, we believe this model ensures that decisions are informed, balanced, and consider both medical and operational perspectives. APIC and SHEA support adopting a co-leader approach which utilizes the full spectrum of infection prevention expertise and is foundational to attain a maximally effective IPC program.

The main goal of these efforts is to elevate the visibility and recognize the value of facility IPC programs across the U.S. and beyond to reach our collective aspirational goals. This position paper and our organizations' combined efforts are critical to securing better resources for our IPC programs. Our associations have been using, and will continue to use, the recommendations

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outlined in our position paper to help institutional decisionmakers, policymakers, and policy influencers make informed decisions, based on a wealth of knowledge and expertise, that impact our ability to advance our organizational objective. A maximally *effective* and active IPC program will enhance any healthcare facility's safety, quality, reputation, and ability to build trust and confidence with patients and their families, healthcare personnel, and the surrounding community.

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