APIC & SHEA PRESIDENTS' WEBINAR

THE FUTURE OF INFECTION PREVENTION & CONTROL

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ARE YOU A MEMBER OF APIC OR SHEA?

Are you a member of APIC or SHEA?

- APIC
- SHEA
- Both APIC & SHEA
- I'm not currently a member of either organization

WHAT IS YOUR PRIMARY PLACE OF PRACTICE?

- Academic Medical Center
- Community Hospital
- Professional School
- Long-Term Care Facility
- Private/Group Practice
- Public Health
- Other

TODAY'S LEARNING OBJECTIVES

GU1

- Review key developments and policy shifts impacting IPC
- Share joint APIC/SHEA actions and emerging initiatives
- Highlight opportunities and challenges for IPC programs
- Identify ways members can engage and take action

GU1 Carol
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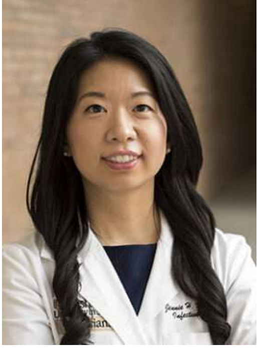

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APIC MISSION AND VISION

APIC Mission:

To advance the science and practice of infection prevention and control.

APIC Vision:

A safer world through the prevention of infection.

SHEA MISSION AND VISION

SHEA Mission:

To prevent and control healthcare-associated infections and advance the field of healthcare epidemiology.

SHEA Vision:

Safe healthcare for all.

GU1

NO OTHER GROUP HAS OUR EXPERTISE OR EXPERIENCE

- 1. Set national and specialty-specific standards for infection prevention and patient safety
- 2. Publish peer-reviewed guidelines, consensus statements, and evidence summaries
- 3. Provide accredited CME/CE programs and oversight frameworks
- 4. Maintain expert networks and advisory collaborations
- 5. Issue implementation resources (toolkits, competency frameworks, practice briefs)
- 6. Advocate nationally and globally for patient and workforce safety
- 7. Lead the scientific and professional agenda for outbreak readiness and safety culture in infection prevention

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GU1 Carol

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GU1

RECENT ACTIONS UNDERMINGING US PUBLIC HEALTH

- CDC
  - Drastic funding and personnel cutbacks (1,000 terminated last week, some rehired)
  - Elimination (HICPAC) or restructuring (ACIP) of advisory panels
    - SHEA liaison members fired in August, along with other liaison members
- HHS
  - NIH: Major cuts in research funding and politicalization
  - AHRQ: Dramatic cuts in research funding; possible "effective elimination"
- Presidential Advisory Council on Combating Antibiotic-Resistant Bacteria (PACCARB)
  - All staff in the White House Office of Infectious Diseases and HIV policy laid off, March 30
  - No staff support for PACCARB; no meetings scheduled; future uncertain
- US Preventive Services Taskforce
  - Meeting cancelled; likely voting members will be fired as with other advisory committees
- Pandemic and All Hazards Preparedness Act (PAHPA) expired, December 1, 2025
  - Top White House pandemic preparedness official (Gerald Parker) resigned, July 30
- Decreased support for vaccine research and use of vaccines

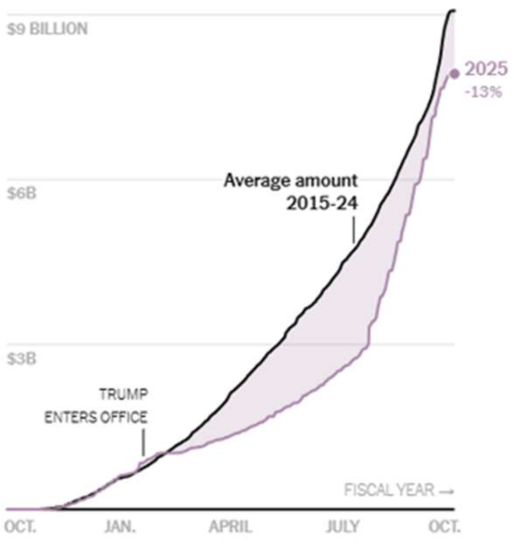

Figure from NY Times, 2/12/25

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GU1 David

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GU1

FUNDING & PERSONNEL REDUCTIONS: FOCUS ON CDC

- Firing of probationary personnel: HHS, CDC, NIH, FDA, AHRQ
- Reduction in force (~20% with additional recent cuts underway; total, ~3,000 employees): HHS, CDC, NIH, FDA, AHRQ (in addition, 154,00 federal employees accepted the buyout offers and 105,000 took regular retirement)
- August 27: Firing of recently Senate approved CDC Director, Dr. Susan Monarez; replaced by Jim O'Neill as Acting Director (Mr. O'Neal) had no training/experience in medicine or public health
  - Key CDC personnel resign in protest including Dr. Deb Houry (Chief Medical Officer and Deputy Director for Program and Science), Dr. Dan Jernigan, (Director of the National Center for Emerging and Zoonotic Infectious Diseases), Dr. Demetre Daskalakis (Director of the National Center for Immunization and Respiratory Diseases) and Dr. Jennifer Layden (Director for the Office of Public Health Data, Surveillance, and Technology).
- Claw back of COVID-19 funding to health departments: Has impact more than COVID-19 programs and led to layoffs, work stoppages, and termination contracts for state health departments.
- Proposed elimination of Prevention Fund which supplies a substantial amount of budget authorization for state ELC programs
- Likely reduction in CDC funding (proposed >50%; $9.3 billion to $4.2 billion; House Subcommitteee proposes cut $1.7 billion): Likely will result in elimination of many programs and services plus substantially reduce funds to support US state, county and city public health services (Federal funding accounts for over half of state and local health department budget)
- Big Beautiful Bill Act (OBBB); signed into law July 4
  - Substantial decrease in Medicaid funding effective end of 2026; likely will lead to closures of critical access hospitals and reduced number of healthcare personnel able to treat indigent patients; implications: delayed healthcare, sicker patients, higher mortality for treatable conditions
  - Likely lower hospital investments/support for infection prevention and control programs, and anti-infective stewardship program
- Elimination for support for research on climate change AND measures to mitigate climate change (e.g., wind power)

GU1 Carol

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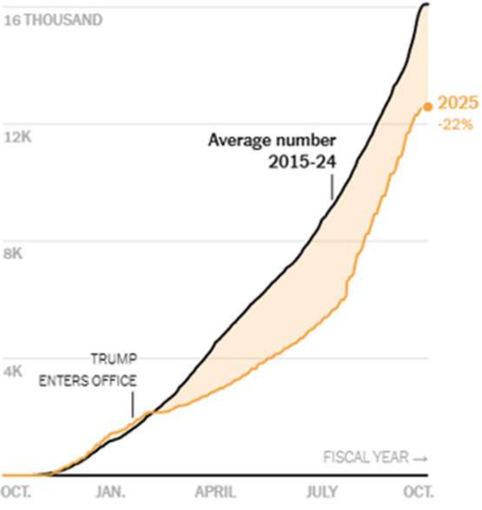
REDUCTIONS IN RESEARCH FUNDING: NIH, AHRQ

- Reduction in NIH funding (NIH = 780 grants terminated; new est. = 2,100)*
  - Focus on chronic diseases at the expense of infectious diseases
  - $2.7 billion cuts January-March; proposed cuts of 40% to overall budget of $48 billion (will lead to ~15,000 fewer medical research projects)
  - Personnel reductions, ~5,000 persons
  - Delays in awarding grants
  - Proposed reduction to 15% in indirect costs
  - US Supreme Court allowed Administration to halt ~$800 million in grants that involved "race" or "gender:"
- Agency for Healthcare Research and Quality
  - AHRQ staff layoffs halted HSR grant disbursement
  - Halting grants = halting HSR research
- Reduction of FDA funding and personnel
  - Increased time for review of new medications and devices
  - Potential elimination of certain medications (e.g., mRNA vaccines)



https://www.cnn.com/2025/04/25/health/nih-science-funding-states-kff-health-news/index.html; *Anil Oza, 27 May; data from April-May

Figure from NY Times, 2/12/25

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GU1 David

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LIMITS ON COMMUNICATION

- Limits on communication between CDC and external stakeholders
- Reduction in transparency (including public involvement/notification)
- Elimination and/or reduction of external advisory committees, HICPAC (or changes in committee membership, ACIP)
- Removal or revision of language on Federal websites (e.g., climate change)
- Elimination of DEI
- Review of all publications (e.g., MMWR) by senior, non-scientific personnel
- Inability of CDC to serve on SHEA committees and/or guideline work groups
- Inability of CDC to participate in SHEA Spring 2025 (April), APIC Annual (June) and **IDW**eek 2025 (October)
- Former U.S. attorney demands scientific journal explain how it ensures 'viewpoint diversity' (Journal = CHEST)
- Consideration of development of new scientific journals and prohibiting NIH investigators from publishing in established journals (e.g., NEJM)

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IMPACT OF US ACTIONS ON WHO AND SUPPORT FOR PUBLIC HEALTH, WORLDWIDE

- Withdrawal from World Health Organization (January 20, 2025)
  - Elimination of US funding of WHO (~16% of 2022-23 WHO budget; ~$1.28 billion)
- Prohibition on communication between CDC and WHO
- Funding cuts for international public health
  - Administrations 2026 budget request proposing a roughly 60% reduction in overall funding, from about $10 billion to under $3.7 billion; cuts will drastically affect major initiatives like the President's Emergency Plan for AIDS Relief (PEPFAR) and the President's Malaria Initiative (PMI), and also zero out funding for Gavi, the Vaccine Alliance
  - Funding for PEPFAR is slated for a 30% reduction; resident's Malaria Initiative would also see a nearly 45% cut.
  - The U.S. government has ended funding for approximately 5,800 global health programs, including those providing vaccines, essential medicines, and emergency care, impacting maternal health, TB, and HIV treatment
  - State Department cuts: The State Department's global health programs saw a proposed 62% funding cut, from $10 billion to $3.8 billion.
  - Potential elimination of ALL Federal funding of HIV/AIDS initiatives, global and domestic
- The administration has dissolved the U.S. Agency for International Development (USAID) and moved its remnants under the State Department. This included firing or furloughing 5,500 employees and canceling 86% of the agency's programs. USAID previously channeled three-quarters of all U.S. global health aid.
- US unprepared to aid in response to a future pandemic (e.g., H5N1, other H5 or N7 influenza strains; novel coronavirus)
- Elimination of support for research on climate change AND mitigation strategies to combat climate change

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GU1 DAVID

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MISINFORMATION AND DISINFORMATION

- Injecting bleach to treat COVID-19 (2020)
- Ivermectin to treat COVID-19 (2020); Secretary Kennedy has recommended allowing this drug to be purchases over the counter (i.e., no physician prescription required)
- Cod liver oil to treat measles (2025)
- Masks not effective to prevent acquisition of aerosol transmitted infectious diseases
- Vaccination risks outweigh benefits; vaccine cause autism
- Climate change doesn't exist (or if it exists, it isn't a problem): Important policy change as climate change altering infectious disease geographic spread, leads to increasing flooding events, and impact AMR)
- DEI is harmful
- COVID-19 vaccine neither safe or effective in pregnant women; CDC had stated "no recommendation" for use but on Oct 7 changed to "shared decision making")

Misinformation and disinformation increasing morbidity and mortality, and leading to increased distrust in science (also increasing vaccine hesitancy)

SHEA
The Society for Healthcare Epidemiology of America

GU1 David

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GU1

IMPACT OF VACCINE EFFECTIVENESS DENIALISM

- Denialism (definition): Denialism is the act of denying the validity, truth, or existence of something, even when there is strong evidence or proof that it is real. It can also refer to the rejection of a body of science in favor of something.
- At a minimum likely pressure to focus on vaccine adverse reactions rather than on vaccine effectiveness in preventing infection and reducing morbidly/mortality
  - Announcements that certain vaccines may be linked to autism (also that acetaminophen use in pregnancy linked to autism)
- Other potential actions
  - ACIP: Replacement of all members largely with vaccine deniers (most appointees have limited vaccine expertise)
    - Likely reduction of vaccines recommended for children (e.g., birth dose of hepatitis B)?
    - Discussion of splitting MMR into 3 separate vaccines
  - Reduction in Federal support for vaccine development: Eliminate for funding for mRNA vaccine development
  - Prolongation of FDA approval for vaccines
  - Elimination of vaccine requirements (e.g., vaccines for school attendance): Florida (likely other states will soon follow)
  - Elimination of certain vaccines (e.g., mRNA vaccines): Laws pending in several states
- Impact: Increased transmission of communicable diseases in healthcare facilities (highest concern is measles followed by pertussis: Both diseases increasing dramatically is US)

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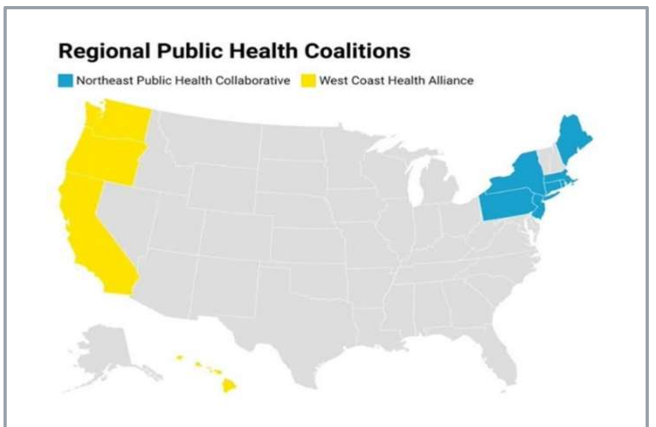
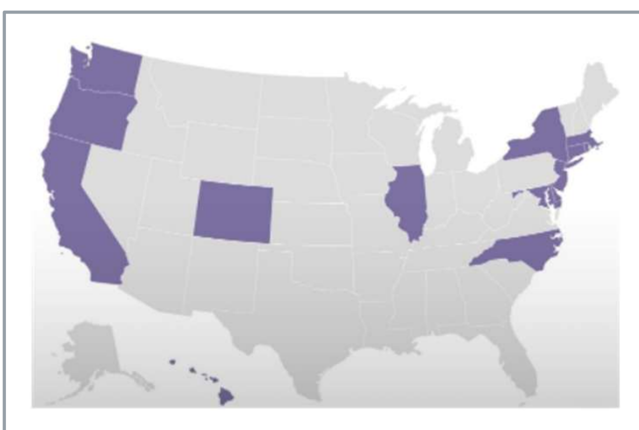
RISE OF REGIONAL HEALTH ALLIANCES





- States forming regional health alliances through bi-lateral agreement: Northeast Public Health Collaborative and West Coast Health Alliance
- 14 state governors (and Guam) recently announced the Public Health Alliance, which will serve as a hub for governors and public health officials to share best practices, exchange data and collaborate on emergency response, vaccine policy and other technical issues, according to a joint statement from the coalition

GU1 CAROL

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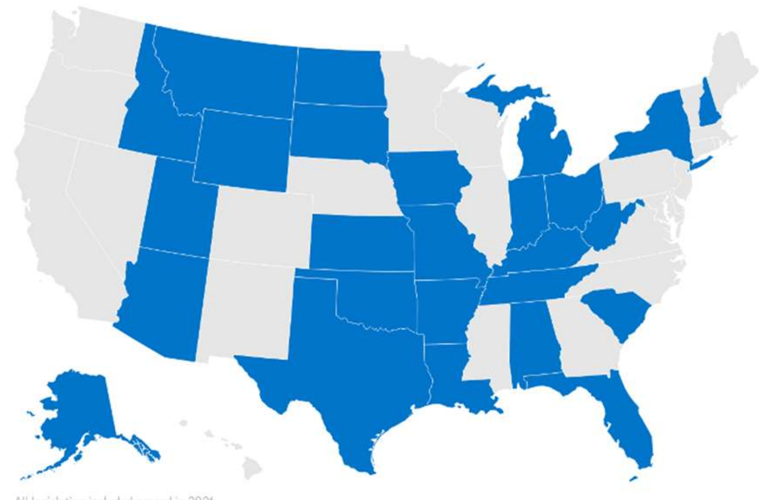
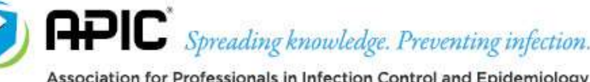
DISTRIBUTED HEALTH POLICY ADOPTION

- States have long been the primary drivers of public health policy, especially in areas like:
- School immunization requirements
- Healthcare-associated infection reporting
- Medicaid administration and reimbursement policies
- Federal agencies like the CDC and HHS provide recommendations, not mandates. States retain the authority to accept, modify, or reject them.
- What's changing now is a shift away from uniform federal guidance. Driven by concerns over scientific integrity and transparency in federal vaccine policymaking
- Professional societies are stepping in to fill the void





GU1 CAROL

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PROFESSIONAL SOCIETIES ROLE

- Professional societies have long developed guidelines and guidance that has driven practice across healthcare.
- Examples include: AAP, APIC, SHEA, and IDSA
- In the realm of infection prevention and control, two major efforts are underway:

○ **The National Adult and Influenza Immunization Summit (NAIIS) Adult Vaccination Recommendations Review (SAVRR) Council**. Made up of 31 associations. Summarizing differences among recommendations from professional medical societies and ACIP

○ **Healthcare Infection Prevention Advisory Group (HIPAG):** Led by APIC & SHEA along with numerous liaisons. Provides national leadership in infection prevention and control (IPC) by developing, updating, and disseminating evidence-based recommendations and supporting CDC and public health partners as needed

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GU1 DAVID
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SHEA RESPONSE

1. **Grassroots Network**. Taken all together, members who actively participate in our advocacy become part of our Grassroots Network. Members get to decide how active they want to be. Opportunities range from emailing letter to Congress to helping to write regulatory comment letters, to representing SHEA as a subject matter expert on external panels to (in rare cases) testifying before Congress.
2. **Public Statements**. SHEA has issued multiple statements pertaining to federal workforce reductions, support for federal advisory committees, research grant funding reform, public health communications, and exiting the World Health Organization. All are available on our website.
3. **SHEA Website**. Finally, be sure to check out the Advocacy section on our web site, particularly the section on Priority Issues. What SHEA is working on: Trump Executive Order – Grantmaking rules; Trump Executive Order Tracker; Federal Advisory Committees; Pandemic Preparedness; FY 2026 Appropriations
4. SHEA & APIC working with Immunization.org on an alternative to the ACIP vaccine schedule
5. Developing MOUs with IPC professional organizations. Current MOUs = Japanese Infection Prevention Society, Asian Pacific Infection Prevention Society (APSIC), collaboration (but not an MOU) with ICPIC. MOUs in development = Hellenistic Infection Prevention Society, Clean Hospitals.

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GU1 David

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GU1

APIC RESPONSE

- Issuing statements related to core values of our profession
- Meeting with Senate and House member offices to elevate our issues
- Responding to regulations as they emerge
- Participating with partners and coalitions
- Planning for greater role in sub-regulatory practice guidance
- Building the new APIC & SHEA Joint Healthcare Infection Prevention Advisory Group (HIPAG)

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GU1 Carol

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HEALTHCARE INFECTION PREVENTION ADVISORY GROUP (HIPAG)

- **A new APIC–SHEA joint initiative to support evidence-based infection prevention guidance**
- Established to help address gaps in national infection prevention guidance
- Provides expert, science-based recommendations to support healthcare and public health
- Brings together leaders from infection prevention, epidemiology, infectious diseases, and related fields
- Will offer structured, consensus-driven input to strengthen consistency across healthcare settings
- More information will be shared with members as the structure and early priorities are finalized

GU1 DAVID INITIATES, CAROL FINISHES (SHARED)

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GU1

ADVOCATING FOR IPC PROGRAM RESOURCES

Raising the Bar: Necessary Resources and Structure for Effective Healthcare Facility Infection Prevention and Control Programs - *SHEA/APIC/IDSA/PIDS Multisociety Position Paper*

- **Target audiences: Healthcare facility leaders, regulatory partners**
- IPC programs
  - have a larger impact than just HAI reduction
  - are essential and foundation parts of all healthcare facilities
  - are under resourced and threatened by unexpected events/emergencies
- Bar should be raised to move programs from "active" to also "effective" against all infectious harms

Slide 23

GU1 David

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GU1

IPC PROGRAM LEADERSHIP: THE EXPANDING ROLE OF THE IP

- Leads strategy and direction for infection prevention programs
- Navigates growing operational, regulatory, and reporting demands
- Builds essential partnerships across clinical, administrative, and public health teams
- Provides expert guidance amid evolving—and sometimes inconsistent—policies
- Ensures high reliability through surveillance, education, and evidence-based practice
- Serves as the organization's trusted authority on infection prevention
- Supported by APIC's leadership development resources, competencies, and pathways for growing future IP leaders

Slide 24

GU1 Carol
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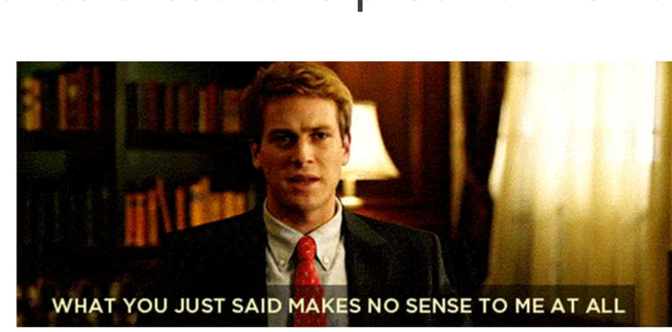
GU1

IPC PROGRAM LEADERSHIP: THE HOSPITAL EPIDEMIOLOGIST

"What exactly does the hospital epidemiologist do?" - *Non-HE IP Leader*

Medical Director for Infection Prevention

- Terminology is technical, confusing, and "academic"
- Does the terminology reflect the roles and competencies?
- Does the title speak to those who provide IPC resources?



APIC® *Spreading knowledge. Preventing infection.*
Association for Professionals in Infection Control and Epidemiology

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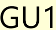
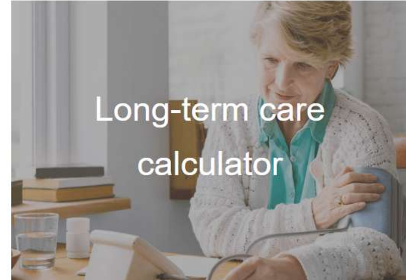


APIC STAFFING CALCULATOR

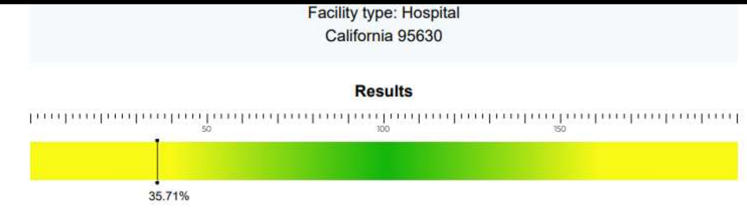
This tool uses input from your facility to provide recommendations to assist with infection prevention staffing decisions.

This beta version* includes three separate calculators:



This version uses existing literature to offer recommendations for staffing based on key risk factors. With user input, the behind the calculator's algorithm will grow over time, and an updated version will be released to reflect the accumulated in 2024. Sharing your data now will help APIC to build the most robust prediction model, and providing feedback on the usability of the calculator will help us to make the tool as user-friendly as possible. Please click below to help us build the version.

Preventing Infections Through Appropriate Staffing (PITAS) Study



Staffing ratio lower than expected

You report a current staffing ratio of 1 IP per **210** beds.

Based on your responses, you have a recommended staffing ratio of 1 IP per **75** beds.

Interpretation

- You reported a staffing ratio of **0.3** FTE to **63** licensed beds.
- In comparison with other facilities with similar complexity, risk, and resources, your responses indicate that your facility staffing is (lower than expected) by **0.54** FTE.

*note that this calculator is in the beta testing phase, prior to final release. The calculations are based on published literature and a small sampling of additional facility surveys. With your feedback, the algorithm will be updated so that the final released version will provide the most optimal results. In that regard, please use discretion with the interpretation and utilization of these results.

Key Influences on Your Results

This section highlights the answers from your responses that influenced the overall calculation. It's a quick way to see how certain inputs affect the staffing ratio results.

Question	Answer	Impact
Does your facility have an Emergency Department	No	+10
Does your facility have a burn unit, stem cell transplant unit, or inpatient rehab?	No	+5
Is there a system surveillance team that conducts surveillance for your facility?	No	-25

GU1 Carol

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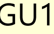

ADEQUATELY STAFFED ASSOCIATED WITH LOWER SIRS

Contents lists available at ScienceDirect

American Journal of Infection Control

journal homepage: www.ajicjournal.org

Major Article

Closing the gap on infection prevention staffing recommendations: Results from the beta version of the APIC staffing calculator

Rebecca Bartles DrPH, MPH, CIC, FAPIC [a,*], Sara Reese PhD, MPH, CIC, FAPIC [a], Alexandr Gumbar SA, CSM, MCSE [b]

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[b] *Association for Professionals in Infection Control and Epidemiology, Information Technology, Arlington, VA*

Key Words:
Infection control
Staffing ratios
Workforce
IPC
Calculator

Background: Published literature suggests "one-size-fits-all" infection prevention and control (IPC) staffing recommendations do not sufficiently account for program complexity needs. This project's objective was to create and validate a calculator utilizing risk and complexity factors to generate individualized IPC staffing ratios.

Methods: An online survey-based calculator was created that incorporated factors intended to predict staffing needs and multiple investigative questions to allow for optimization of factors in the algorithm. Hospital characteristics, staffing ratios, staffing perception, and outcomes were analyzed to determine the optimal questions and benchmarks for future releases.

Results: The median infection preventionist full-time equivalent to bed ratio was 121.0 beds for 390 participating hospitals. The calculator deemed 79.2% of respondent staffing as below expected. Significant association existed between higher standard infection ratio ranges and staffing status for central line-associated bloodstream infection (P = .02), catheter-associated urinary tract infections (P = .001), *Clostridioides difficile* infections (P = .003), and colon surgical site infections (P = .0001).

Conclusions: This novel approach allows facilities to staff their IPC program based on individual factors. Future versions of the calculator will be optimized based on the findings. Future research will clarify the impact of staffing on patient outcomes and staff retention.

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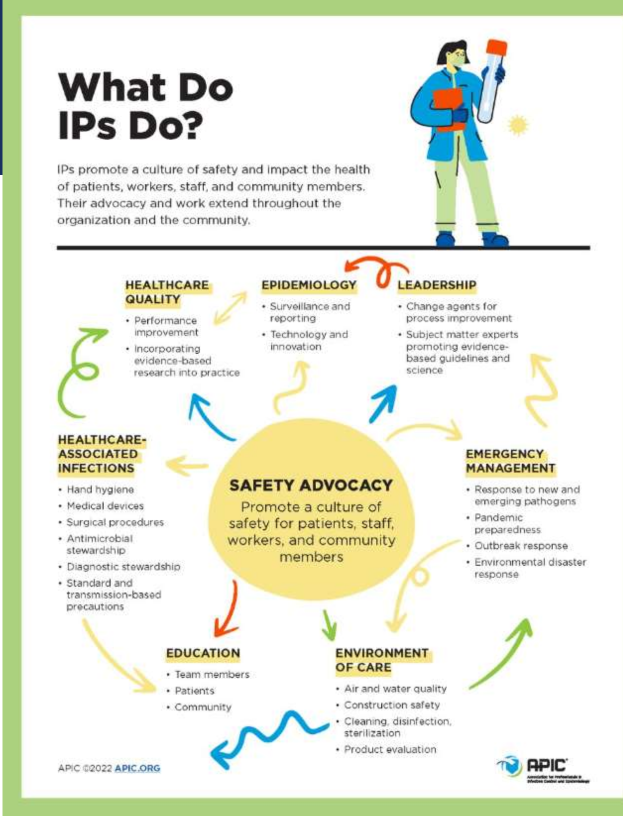
OPPORTUNITY: SUPPORTING IPC PROGRAMS

- Tools (job descriptions, reporting structures, career ladders)
- Commentary in target audience venues
- Leverage regulatory partner work and expectations
- Pathways to enter field (IP Academic Pathway)
- Opportunities for scientific contributions
- Regulatory requirements for staffing (LTC)



GU1 BOTH?

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TURNING REGULATORY CHALLENGES INTO IPC OPPORTUNITIES

- CDC Funding
  - Societies advocate for this expertise and voice
- Expansion of home care & the IPC challenges
  - Societies sent a letter to joint commission to respond to the IPC elements in their home care guidance
- Long term care staffing
  - NEW Multisociety guidance for IPC in nursing homes calls for at least one IP per LTC facility
  - APIC working on education and training with LTC groups; specific certification
- IFU Management
  - APIC undergoing initiative to better manage these challenges, SHEA to partner when possible

GU1 DAVID

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GU1

OPPORTUNITY: ADVANCING IPC

- The Joint Commission and DNV
  - Take effective IPC Program definition and expectations into considerations for surveying organizations
  - Standards created and reviewed by infection prevention experts
- Advocate for more IPC experts on standards writing groups
  - APIC & SHEA submit names to writing groups, quality measures, etc.
- Continue to work with public health and provide input to public health guidance

GU1 CAROL

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GU1

EMERGING OPPORTUNITIES IN INFECTION PREVENTION

- **AI:** Support surveillance & decision-making while protecting privacy and minimizing bias
- **Sustainability:** Align environmental goals with safe, effective infection prevention
- **DEI:** Build a more diverse workforce and address disparities in infectious risks

GU1 DAVID
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GU1

CONTINUED PARTNERSHIP

- Joint sessions in 2026 at SHEA Spring and APIC Annual Conferences
- Ongoing opportunities
  - Joint advocacy in a new era of need
  - Increase awareness of the impact of successful IPC programs and the resources needed to ensure that programs are effective
  - Discuss opportunities for APIC/SHEA partnership with regulatory and public health entities to advance IP practice and improve health equity
- Continue joint leadership meetings to focus on areas of overlap
- Continue to jointly advocate for more federal, state, and local public health funding

GU1 CAROL
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GU1

JOINT APIC/SHEA PARTNER GOALS

- Standardized minimum staffing levels—incorporated into accreditation or regulatory requirements
- Adequate compensation commensurate with our level of expertise and contributions to patient and healthcare personnel safety
- Workforce pipeline development
- Recognition as the IPC experts
- Actively communicate the value of IPC to a broad range of audiences
  - Healthcare systems, policy makers, payers

GU1 DAVID
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GU1

WHAT YOU CAN DO

- Respond to APIC and SHEA calls to action to respond to legislators
- Take advantage of SHEA and APIC volunteer opportunities
- Serve as a peer reviewers for journal articles
- Submit research/posters on new approaches, fresh ideas to conferences
- Send us your ideas!
  - Informal feedback
  - Reach out to Board members
  - Reach out to APIC and SHEA staff

Slide 34

GU1 BOTH?

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NEW PRESIDENTS FOR 2026!

APIC 2026 President
Kathy Ward, RN, BSN, MPH, FAPIC, CIC
Infection Preventionist, Team Lead
Roper Hospital
Charleston, SC

SHEA 2026 President
Lisa Maragakis, MD, MPH
Senior Director of Infection Prevention & Hospital Epidemiologist
Johns Hopkins University School of Medicine
Baltimore, MD

QUESTIONS?

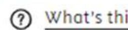
OPPORTUNITY: SUSTAINABILITY & INFECTION PREVENTION

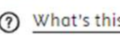
- Measuring safety and sustainability
- Larger issues around climate change and healthcare's impact – what are IPC roles and responsibilities?
- Working with vendors on design

OPPORTUNITY:
ARTIFICIAL INTELLIGENCE

- Need to ensure it supplements expertise & **does not replace**
- Work to use it for large data models to help as a prevention tool
- Need to monitor, study and better understand how it's being used
- It is coming – no way to stop – just work to manage expectations and use, privacy

American Journal of Infection Control
Available online 14 March 2024
In Press, Corrected Proof





What's this?

Major Article

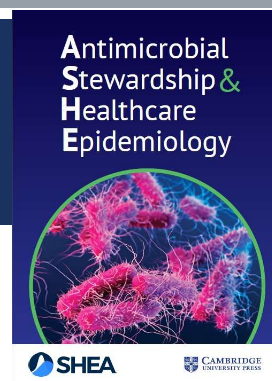
Assisting the infection preventionist: Use of artificial intelligence for health care–associated infection surveillance

Timothy L. Wiemken PhD, MPH [a], Ruth M. Carrico PhD DNP [b]

OPPORTUNITY: DIVERSITY, EQUITY, INCLUSION IN IPC

- Supporting studies on health equity
  - APIC Health Equity Committee: 2 papers: focus groups to explore health equity in IPC
- Highlight health equity issues in our research programs, journals
  - APIC's Center for Research, Practice, and Innovation (CRPI)
- Workforce diversity
  - APIC IP Academic Pathway – opportunity to develop curriculum in minority serving institutions and HBCU
  - IPC professional background diversification (MPH, RN, Micro, Lab, etc.)

OPPORTUNITY:
IMPACTING DIVERSITY, EQUITY, INCLUSION IN IPC



- Comprehensive efforts to enhance diversity of volunteer roles, committee memberships/chairs, BOT, speakers, authors
- Leadership training
- Focused content within society publications
- Identify and implement pathways for a more diverse workforce earlier in their career
- Advocacy re: addressing health disparities (e.g., in research efforts, understanding of HAI/AS outcomes and measures)

STRATEGIC MAP: 2022-2026

A

MEMBERSHIP

Embed diversity, equity, and inclusion within SHEA volunteer structures to advance DEI principles in the fields of healthcare epidemiology, infection prevention, and antibiotic stewardship.