PRESIDENT’S MESSAGE*

I take this opportunity to share with you my thoughts on the future directions of the practice of infection control. Infection control practice, although it has always played an important part in health care, is a relatively new discipline. Over the years, however, we have seen our practice evolve, grow, and reach a much greater level of structure and sophistication. It is important for us to recognize this growth, and to assess our future we should be asking ourselves several important questions such as:

- What are the strengths we possess to assist us in today’s changing health care environment?
- Where should we direct our energies and activities to secure our place and our profession in the medical system and in this new era of health care?
- Is our profession evolving to meet the needs of our society and the health care system?

The following are my brief observations concerning these questions:

To prosper in the twenty-first century, we

must adapt, define our role, and be willing to expand our practice. Change is an inevitable reality. We must be flexible and adaptable enough to change, recognizing that with changes come increased responsibility and reliance in this dynamic health care environment. We must go forward, be creative, and be open to expanding our scope of practice.

John Naisbitt, in his book *Megatrends*, discusses the directions in which society is moving that are transforming our lives. I think we must also critically evaluate our directions by comparing our profession with the trends of society.

First, Naisbitt identifies a trend toward a shift from an industrial society to an informational and service-related society. The process we, as infection control practitioners go through each day is one of information gathering, evaluation, and dissemination of information. The role of the ICP as teacher, investigator, researcher, patient advocate, agent of change, consultant, statistician, role model, coordinator, and politician will keep us in tune with the informational society, especially as it relates to health care. We must learn to effectively communicate our knowledge with the key people in health care and to communicate in a language that they can understand and relate to. We must start to evaluate the implementation of infection control programs for cost-effectiveness, and then we must communicate this information. We must sell our product and services. The information we possess as professionals involved in our practice is our most valuable asset, and we must use it to our full advantage and that of the patient. Infection control people need not drown in data, but must learn to plan strategies for our programs and selectively communicate pertinent information that will be effective in our preventive efforts.

Society is moving into a high-tech, high-touch technology, as all of us working in the health care field can attest. We have already seen the explosion of high-tech in health care with the introduction of sophisticated medical technology such as scanners, lithotripters, microsurgery, and transplantation of multiple organs and of course data information systems. However, Naisbitt said, the more high-tech hospitals become, the less we are being born and dying there, and the more we are avoiding them in between. I recently read a magazine that quoted a health official who said, “Just staying out of the hospital can save lives.” Thus, what is happening in health care is the trend toward the emergence of more home births, home care programs, hospice care, and even homelike environments within the hospital itself. These trends should challenge each of us to keep pace with the changing technology, as well as recognize the opportunities for infection control practice outside the traditional setting. If we do not take the initiative and adapt to these changes and provide leadership, others will.

Society is moving toward planning for the short and long term in health care. April’s *U.S. News & World Report* discusses the recent changes occurring in length of stay. Twenty years ago a patient with a hernia was hospitalized for 2 weeks, immobile and at risk of virulent hospital-borne infections. The trend today is toward earlier discharge. Hospital discharges to nursing homes jumped 40% in the first 18 months after the implementation of the Medicare prospective payment system. The elderly, those 65 years of age and older, were primarily affected by these changes. Diagnosis-Related Groups (DRGs) and the prospective payment system are a direct result of the government’s approach to problems in dealing with the high cost of medical care, because there are approximately 30 million elderly receiving Medicare benefits for which the government pays. The changes that prospective reimbursement have caused in the delivery of care are forcing us to change our practice as well. We should recognize the increasing acuity level of the elderly patients being discharged to nursing homes and promote our infection control efforts in these institutions. We must also document the effectiveness of our preventive efforts, to justify our programs. When the health care environment or social environment changes, so must our profession look at the role of the practitioner and adjust our goals to fit. Naisbitt said that if we are not in tune with the changes in society, we will end up tombstones in a large professional graveyard. Think about it!

Although our practice has traditionally been very specialized, we also must recognize that
we cannot specialize into obsolescence. The 1985 APIC Position Paper describes epidemiology as providing an organized framework for problem solving and decision making. Through the infection control practitioner's education and experience, we are able to integrate the principles of epidemiology into clinical practice. Data in hospitals are now being collected by a number of different individuals and departments and often by people with little background or knowledge in proper collection and analysis methods. With our epidemiologic skills, we are in a unique position to expand and organize these data and manage other risk areas.

We must strive to expand our knowledge base and apply the skills and knowledge we already possess to other areas of epidemiology. We have to assume an active role in defining our own future. The key is adapting to changes occurring in the workplace and assuring recognition for the expertise that we already possess and can apply in other areas of health care. We are also moving from a centralized to decentralized society. If we are to stay in pace we must not only control our profession from a national level, but also strengthen our local and regional bases. We will become stronger by working together toward building strong chapters that are supporting a strong national organization. Uniting the profession by working together and sharing, on a local level to a national level, will gain us strength to control and shape our future successes. Only then can we provide the information and education to remain dynamic, successful professionals. Networking is a method often used by professionals. Networking includes communication between practitioners and other health care professionals, but it is more than talking. It includes membership in professional organizations, attendance at educational conferences, writing for your professional journal, participation at chapter meetings, communication through professional newsletters, and of course maintenance of the infection control grapevine. We participate in networking to grow professionally and to share available resources that assist us in the delivery of high quality health care to our patients. Through the exchange of information, networks offer what bureaucracies can never. Networks provide a linkage among professionals. The Commentary in April's American Journal of Infection Control (Weinstein) suggests the need for infection control internship programs. All new practitioners need mentors, and most of us have served as a mentor to novice practitioners by giving advice, support, and counsel when needed. This role modeling should continue and be encouraged.

As society and health care move from institutional help to ambulatory and self-help, infection control professionals need to expand into these untouched areas in the community. Medicare payments for home health services cost over $1.4 billion yearly. As infection control practitioners, we cannot ignore the trend toward home health and should recognize this as an opportunity to become a part of the home care team. Consumers need to know of infection control and prevention and recognize that we are patient advocates. We must remember that our clients are making more decisions about their own medical care, and we must assist them. Teaching potential clients about nosocomial infections is an avenue for increasing awareness about our profession. It is our responsibility to inform our patient population of the risks of nosocomial infections and of ways to prevent occurrences.

Reaching out to the public will also bring rewards to our profession. It is our responsibility to focus our activities toward programs that highlight the importance and cost-effectiveness of infection control programs. We must utilize the media, both nationally and locally, to reach people with our message. We need to reach out in a coordinated effort and highlight the importance of infection control programs in promoting high quality health care. In 1986, APIC, through a generous grant from Stuart Pharmaceuticals, disseminated a public service announcement on infection control to more than 200 television stations across the country and to all APIC chapters. More than 38 million people in the United States have already seen our message on infection control.

Many of you have participated in our efforts to pass a bill proclaiming a National Infection Control Week. It is with extreme pride that I
announce that on May 5, 1986, this bill, S. J. 147, received the needed signatories and will be reported out of committee and introduced on the floor of the U. S. House of Representatives. After four APIC Annual Educational Conferences and four Presidents, we are now on our last step in the legislative process for achievement of a National Infection Control Week.

Because of our training, education, and practice, we as professionals are in an ideal position for change—to grow and to prosper. We must become leaders in disease prevention and patient advocacy. Our energies must be directed to improvement of the patient environment through our cooperative efforts with the health care community. And yes, our profession is evolving to meet the needs of society, through your personal efforts to consistently improve, and through your organization by providing information and educational programs that are timely and leading edge. I firmly believe that APIC's building advocacy and activism for high quality patient care will take us well into the twenty-first century. Remember, we all will prosper by working together—we are professionals.

THE WHITE HOUSE
WASHINGTON
May 3, 1986

I am pleased to extend greetings to all those gathered for the 1986 meeting of the Association for Practitioners in Infection Control.

Through the efforts of your organization, the rate of hospital-acquired infections has dramatically decreased. As pointed out by the recent Study on the Efficacy of Nosocomial Infection Control or SCERIC project, the medical world is fast approaching the day when one-third of all hospital-acquired infections will be prevented. These accomplishments reflect well upon your organization.

Our world is faced with new and more complex medical problems every day and only through the concerted efforts of groups like yours will it be possible to treat and prevent them.

Your dedication is highly commendable. Nancy joins me in extending our best wishes for your continued success. God bless you.

Ronald Reagan

BOARD ACTION

On May 2 and 3, 1986, the Board:

1. Ratified the following committee memberships:

   Education Committee
   Rosemary Berg
   Virginia Kennedy
   Kathy Miller
   Loretta Copper
   M. Louise Jones
   Barbara Tuthill
   Diana McPherson

   Research Committee
   Elizabeth Bolyard
   Debbie Coleman
   John H. Keene
   Elaine Larsen
   Nancy Parris
   Barbara Terry
   Tim Townsend

   Abstract Subcommittee
   Joe Klimek
   Joell Bowab
   Linda Laxson
   Elene Rock
   Susan Slavish

   Nominating Committee
   Nancy Beuerle
   Peggy Flynn
   Joanne B. Keene
   Sally Reeves
   Karen Rupert

   1986 Program Committee
   Joell Bowab
   Linda Laxson
   Nancy Click
   Joe Klimek
   Susan Slavish
   Jeanette Daniel
   Katherine Hubbard
   June Constantino

   Personnel Utilization Task
   Force
   Robert Sharbaugh
   Elizabeth Bolyard
   Terry Yamauchi
   David Taylor

   Awards Committee
   Terry Yamauchi
   Sherry Furr
   Lee Illing
   Connie Hall
   Becky Scott
   John McGowan

   Standards Committee
   William Rutala
   Sherri Epstein
   Deborah Sampson-Ripley
   John Boyce
   Ed Septimus
   Loretta Frawley

   Personnel Utilization Task
   Robert Sharbaugh
   Elizabeth Bolyard
   Terry Yamauchi
   David Taylor

   Budget and Finance
   Darnell Abbott
   Margaret Flynn
   Angela Goetz
   Patricia Schlegel
   Nina L. Smith
   Richard Munsinger
   Dona Haney
   Mary Barlow
   Arlene Potts
   Karen Getz
   Joanne Bakken