

Certification—the new expectation for IPs

BY RICH CAPPARELL, NANCY HAILPERN, AND LISA TOMLINSON

APIC'S STRATEGIC PLAN 2020 (SP 2020) set a goal for infection preventionists (IPs) related to competencies and certification that called on the organization to “*Define, develop, strengthen, and sustain competencies of the IP across the career span and support board certification in infection prevention and control (CIC®) to obtain widespread adoption.*”

In response to SP 2020, APIC set the following desired outcomes:

- The majority of IPs will demonstrate core competency in infection prevention and control through board certification.
- The role and value of IPs will be strengthened through greater adoption of a standardized credential.

To measure progress toward these outcomes, the organization’s leadership developed an ambitious 2020 target of 10,000 CICs, and began measuring progress toward that goal in 2012.

Greater confidence and opportunity

Professional certifications are required for many industries and are particularly prevalent in healthcare. Similar to board certification for physicians, certification in a wide range of fields—from finance to education—is now an expectation for employment. Certification is seen as a win-win for employers, employees, and other key stakeholders, and is becoming the norm as employers seek an edge in their industry and hiring managers look for applicants who have demonstrated a willingness to invest in their careers. This can provide greater confidence in identifying candidates, and give an opportunity for IPs to show their qualifications and dedication.

Better outcomes for patients

There is growing evidence that **IPs with a CIC have better patient outcomes.** According to studies, hospitals whose



PHOTO CREDIT: ORHAN CAM/SHUTTERSTOCK.COM

“Professional certifications are required for many industries and are particularly prevalent in healthcare. Similar to board certification for physicians, certification in a wide range of fields is now an expectation for employment.”

infection prevention and control (IPC) programs are led by a CIC have significantly lower rates of methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infections, and lower rates of catheter-related bloodstream infections.¹⁻² Credentialed IPs

are two to three times more likely to perceive the evidence of certain infection prevention practices as strong. This perception of evidence may explain why certified IPs are more likely to implement certain infection control measures.³ Furthermore, research has

shown, IPs with a CIC are better prepared to interpret evidence and act as champions for key infection prevention practices within their facility.²

An expanded and varied role

APIC is constantly evaluating the future of infection prevention and the role IPs will play in healthcare for years to come. Since the early 2000s, there has been a greater emphasis on evidence-based medicine and better outcomes for patients, putting infection prevention front and center in the C-suite, and with state and federal policymakers.

At the same time, IPs come to the profession from a variety of disciplines, backgrounds, and pathways to the profession. This may raise the question for healthcare leaders of “how do we know this individual has the knowledge to serve as an IP in our facility?” CIC is the only recognized credential that ensures that someone working as an IP is knowledgeable in the

field. Is it possible for individuals without such a credential to be competent and knowledgeable? Yes, of course. But the Certification Board of Infection Control & Epidemiology, Inc. (CBIC®) is the only CIC credentialing body that fairly tests for such knowledge.

The level of variation in the role of an IP also impedes recognition by state and federal policymakers. When you look at most state and federal statutes, the role of an IP is ill-defined at best, and in most cases does not exist. With little standardization within facilities, and state and federal authorities, the role and expertise of the IP is widely misunderstood or even overlooked. The inconsistency from region to region could have long-term impacts on the field of IPC and the future of IPs in the healthcare field. Setting the expectation that new entrants to the field become certified provides healthcare facilities and patients with a universal baseline of knowledge.

With that baseline, IPs can better craft the future of their role in healthcare.

Phasing in a certification requirement for new IPs

During its fall meeting, the APIC Board of Directors supported a plan to begin a conversation with the APIC membership about phasing in a CIC certification requirement for new IPs. We look forward to further conversations with you about this approach in the coming years.

For comments or questions about legislative proposals regarding mandatory certification, please contact the APIC Public Policy team at legislation@apic.org. 

References

1. Pogorzelska M, Stone PW, Larson EL. Certification in infection control matters: Impact of infection control department characteristics and policies on rates of multidrug-resistant infections. *Am J Infect Control* 2012;40(2):96-101.
2. Krein SL, Hofer TP, Kowalski CP, et al. Use of central venous catheter-related bloodstream infection prevention practices by US hospitals. *Mayo Clin Proc* 2007; 82: 672-678.
3. Saint S, Greene MT, Olmsted RN, et al. Perceived strength of evidence supporting practices to prevent health care-associated infection: results from a national survey of infection prevention personnel. *Am J Infect Control* 2013;41(2):100-6.

TABLE 1: STATE CIC® REQUIREMENTS

State	Summary of Code Related to CIC
<p>Colorado CO §25-3-602</p>	<p>An individual who collects data on healthcare-associated infection rates shall take the test for the appropriate national certification for infection control and become certified within six months after the individual becomes eligible to take the certification test, as recommended by the Certification Board of Infection Control and Epidemiology, Inc., or its successor. Mandatory national certification requirements shall not apply to individuals collecting data on healthcare-associated infections in hospitals licensed for fifty beds or less, licensed ambulatory surgical centers, licensed dialysis treatment centers, licensed long-term care facilities, and other licensed or certified health facilities specified by the department. Qualifications for these individuals may be met through ongoing education, training, experience, or certification, as defined by the department.</p>
<p>Nevada NV ST 439.873</p>	<p>If a medical facility has 175 or more beds, the person who is designated as the infection control officer of the medical facility must be certified as an infection preventionist by the Certification Board of Infection Control and Epidemiology, Inc., or a successor organization. A person may serve as the certified infection preventionist for more than one medical facility if the facilities have common ownership.</p>
<p>New Jersey N.J.A.C. 8:43G-14.3</p>	<p>The infection control professional shall have education or training in surveillance, prevention, and control of nosocomial infections. The infection control professional shall be certified in infection control within five years of beginning practice of infection control and shall maintain certification through the Certification Board of Infection Control, Inc.</p>