Change is the only constant in health care—Today’s health care industry is a fluid system, constantly in motion, constantly changing. For professionals in infection control and health care epidemiology, the system’s rapid changes often involve job insecurity amidst mergers, acquisitions, and downsizing that now appear a “constant” as well.

Today, the health care business is highly regulated, politically and economically complex, and extremely competitive. Within every health care organization, there is an infection control professional (ICP), most often a sole practitioner or a team member responsible for some type of organizational quality improvement. Historically, infection control and epidemiology (ICE) programs are not revenue generators, and unfortunately for prevention programs, revenue is what drives most of the health care industry. Over the last few years, ICPs have been eager to learn about the business of health care and how the ICE program fits in their organization’s business plan. Demonstrating the value of this program has become more necessary as health care executives are faced with increasingly larger problems and smaller budgets with which to solve them. Applying sound epidemiologic principles to every project we manage, marketing our expertise and skill sets, developing and implementing data-driven interventions, and understanding the cost/benefit of our services must become as routine to today’s ICPs as finding health care–associated infections.

Patient safety, unfortunately often discussed without including infection prevention and control, is now the language to learn and the toolkit to build. Ensuring a safe environment for patients and employees must be part of the mission statement for any ICE program to survive and thrive.

Being part of any new health care movement or shift in program direction involves change. ICPs are perfectly situated to become change agents, as our practice has been based in patient safety and health care employee safety for many years. However, today our movement forward into patient safety must begin with a change in the way we see ourselves as ICPs and epidemiologists. This message to our community is not new; it has been presented for years. Five years ago, Marguerite Jackson1 warned ICPs that if we were not willing to change with the health care environment, we could be buried like the dinosaurs. She provided tools for ICPs to navigate their way through managed care and create opportunities for the future. In 1998, APIC President Frances Slater2 opened the APIC national conference, encouraging ICPs to manage change and demonstrate their value, to build our business much like independent contractors, to uphold a reputation for quality, and to satisfy the people who pay for our services. Garcia et al3 provided us with a framework in 2000 to rethink the business of infection control, calling it interventional epidemiology: focusing on clinical outcomes, costs, and customer satisfaction. Julie Gerberding4 of the Centers for Disease Control and Prevention (CDC), addressing 2001 APIC conference participants, challenged every ICP to embrace this new approach, to reliably measure and drive improvement in clinical outcomes and cost, and to intervene when we identified processes that placed our patients at risk for infection or other adverse events.

The choices to be made are clear: ICPs can choose a leadership role, they can choose to be a strong mem-

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ber of the team, or they can stay in their traditional role and hand over the data. Those who have taken these messages to heart are likely to, at the very least, survive in their organization and be included in its efforts to establish comprehensive patient safety programs. For those who have not yet embraced this change, it is never too late to secure your place at the table!

This special issue of AJIC is a compilation of ideas, plans, strategies, information, examples, tools, and methods that can assist ICPs interested in moving their business to another level. Authors Fraser and Dunagan discuss, from the perspectives of a hospital epidemiologist and a health care executive, the business of infection control, its place in the quality improvement arena, the caveats involved in linking infection prevention to cost savings, and a vision for service excellence in ICE. In their article, Soule and Murphy describe methods, tools, and examples for strategic planning, creating a mission and vision for ICE programs, and implementing interventions that have proven to reduce health care–associated infections. Pugliese, Lundstrom, and colleagues review and discuss the importance of a culture of safety and the impact the environment has on health care workers and, ultimately, on patient outcomes.

In the May issue, we are provided with additional tools and methods used by health care epidemiologists to help us manage effective ICE programs. Reminding us that a thorough literature search is the foundation for all health care endeavors, Shojania and Olmsted outline appropriate steps in searching and critiquing scientific literature, critical for building programs based on the science of epidemiology. Authors Stone, Larson, and Kawar provide us a review of the literature on the financial impact of health care–associated infections, information always necessary in discussing the cost/benefit of our business. Internal partnerships to expand the reach of ICE teams are demonstrated by Wright and colleagues as they discuss developing an infection control liaison position in their organization. Utilizing severity-of-illness markers to predict ICU associated infections will be presented by McCusker, Perisse, and Roghmann from the University of Maryland.

These 2 issues are devoted to offering ICPs alternative approaches for consideration to improve upon their existing program and business plans. Readers will find 2 messages consistently presented in the articles. First, partnerships are critical to success. The second message may not be as direct, but the authors agree that any business or system is designed to deliver the product or outcome it gets and any outcome it gets is a product of its system design.

The mission of ICE programs is to reduce infections. Errors in health care, which may include nosocomial infections, are most often a result of flawed systems—processes that set people up to fail—rather than uncaring health care workers who are not interested in safe, positive outcomes for their patients. Patient and employee safety depends on process improvement and people dedicated to the business of prevention—a business in which infection control professionals are, or can be, the experts!

References