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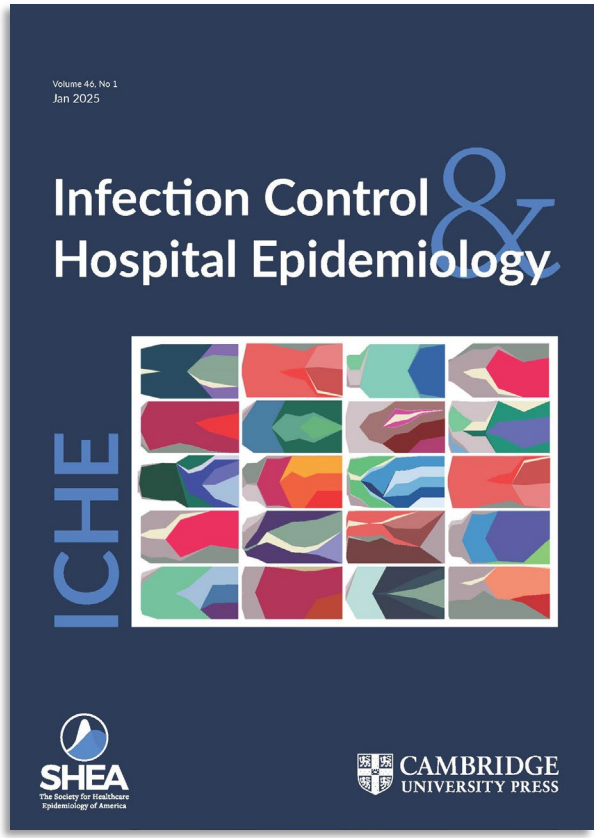

Infection Control & Hospital Epidemiology publishes scientifically authoritative, clinically applicable, peer-reviewed research on control and evaluation of the transmission of pathogens in healthcare institutions and on the use of epidemiological principles and methods to evaluate and improve the delivery of care. Major topics covered include infection control practices, surveillance, antimicrobial stewardship, cost-benefit analyses, resource use, occupational health, and regulatory issues.

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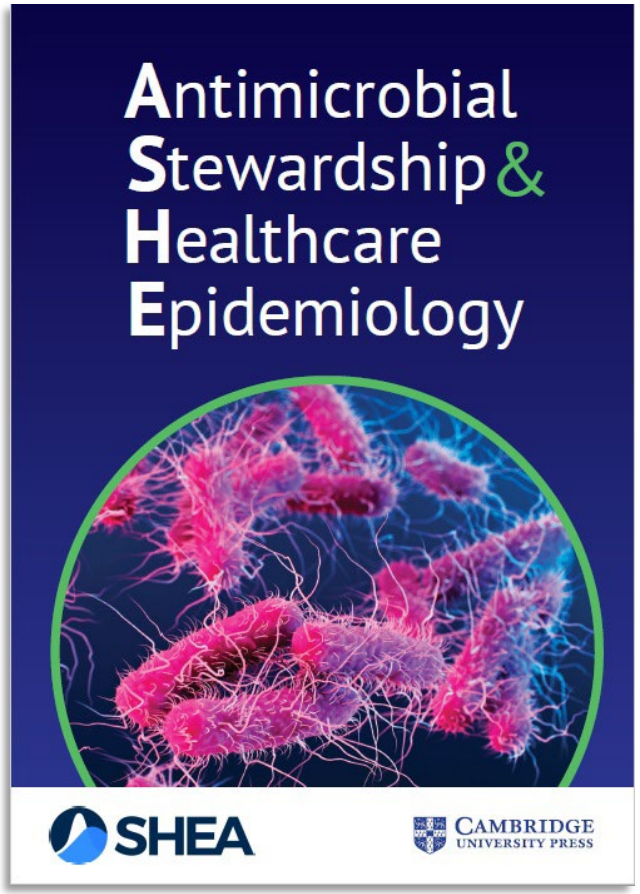
ASHE JOURNAL



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Online ID Fellows Course

Primer on Healthcare Epidemiology, Infection Control & Antimicrobial Stewardship

SCAN TO LEARN MORE

NEW!

SHEA Members Open Forum

Get ready for real discussion! This is a peer-driven, discussion-based program designed for SHEA members to connect, share experiences, and talk through real-world challenges.

February 25th at 4:00 – 5:00 pm ET

Moderator: Harjot K. Singh, MD, MSc

Topic: Infection Control Conversations: Preparedness & Response

SHEA

COMING SOON

You Can Help!

Improving Antibiotic Stewardship and Infection Prevention in Nursing Homes

eLearning Course


MALAYSIA
APSIC
2026
12th INTERNATIONAL CONGRESS OF
ASIA PACIFIC SOCIETY OF INFECTION CONTROL
Kuala Lumpur Convention Centre, Malaysia
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APRIL 7 - APRIL 10
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SHEA Webinar

Town Hall 2026

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Housekeeping

- Technical difficulties? Visit: https://support.zoom.us
- Webinar recording, PowerPoint presentation, and references available on learningce.shea-online.org
- Streaming Live on SHEA's Facebook page
- Zoom Polling, Q&A & Chat

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February Town Hall Panelists:

Dr. Bernard Camins
Mount Sinai

Dr. Katie Passaretti
Advocate Health

Dr. Chris Nyquist
Children's Colorado

Dr. Tom Talbot
Vanderbilt University

Invited Panelist:

Rebecca Stern, MD
Vanderbilt University Medical Center

ADVOCATE HEALTH

Ambulatory Infection Prevention

SHEA Town Hall

February 17, 2026

Shifting Risk Portfolio

- Outpatient visits up > 30% over past 20 years
- Massive growth of ASC with shift of inpatient procedures to outpatient
- Hospital level care provided at home
  - 9/2025 per AHA – 419 hospitals across 147 systems in 39 states with HAH program
- Growth of home health care/OPAT
- Despite growth, often limited trained IP support/dedicated resources

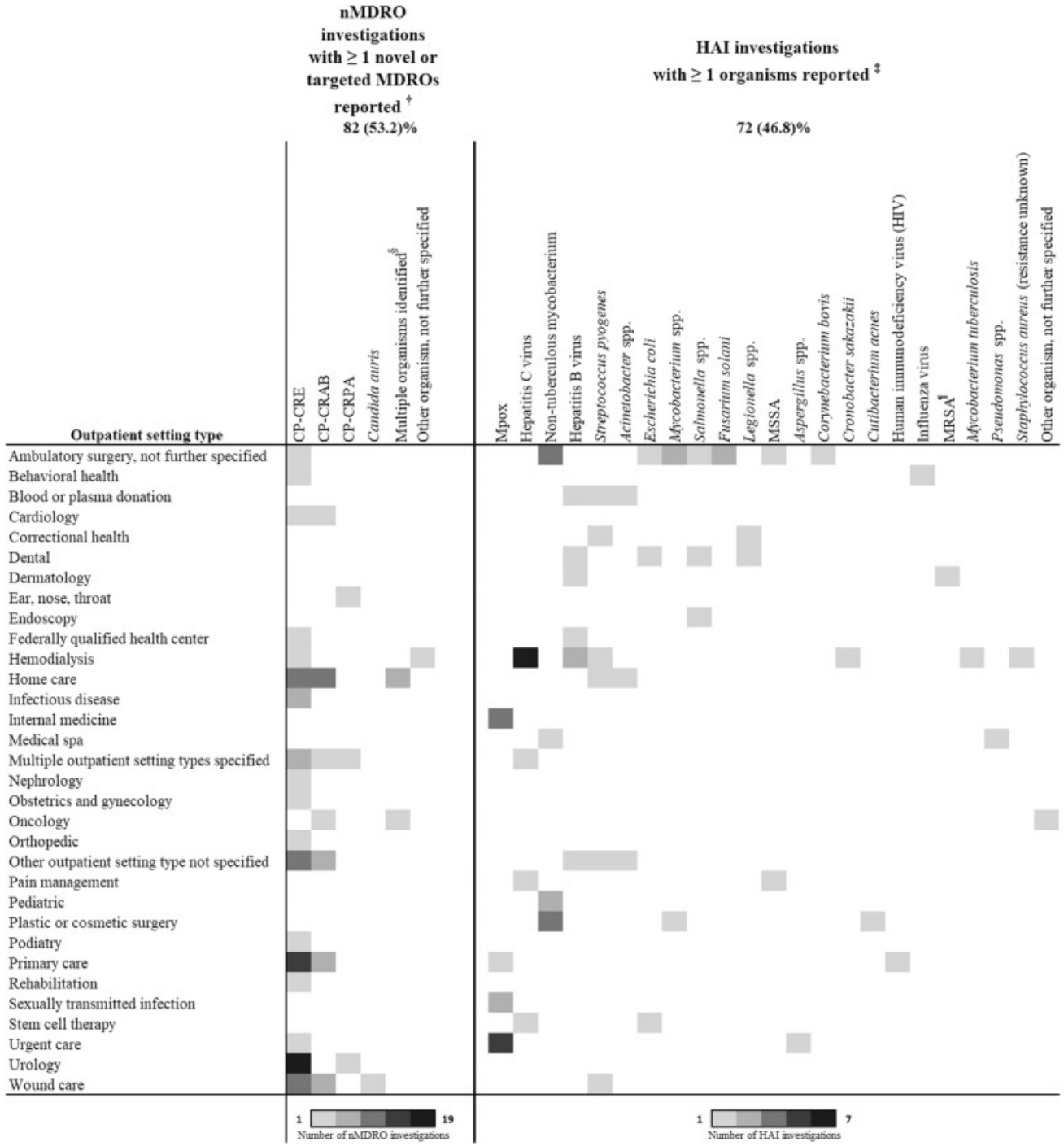
Outpatient Outbreaks

Public health investigations in outpatient healthcare settings nationwide, August 2019 to July 2023

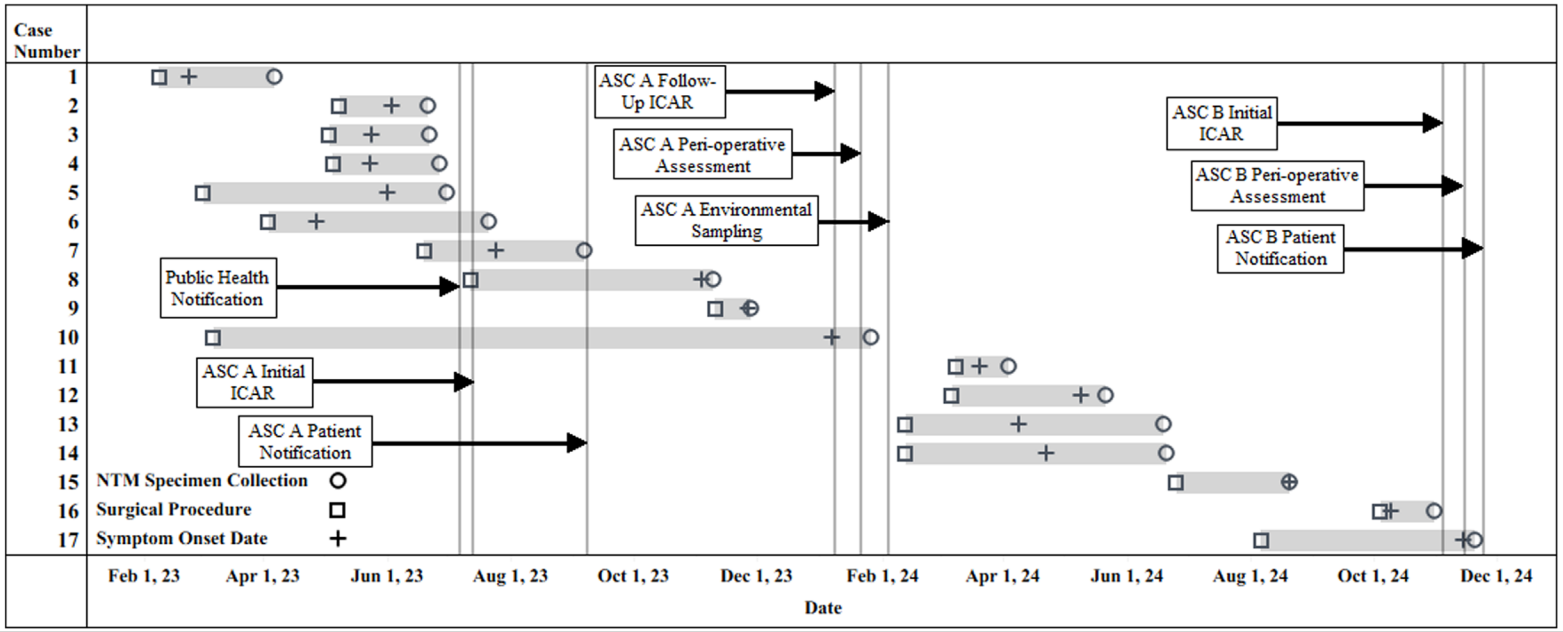
Austin R. Penna, MPH, CIC · Nijika Shrivastwa, PhD, MHSA, MPH · Penelope Strid, MPH · Joseph F. Perz, DrPH, MA · Jennifer C. Hunter, DrPH, MPH

Affiliations & Notes Article Info

- 8% health department investigations involve 1 or more outpatient settings
  - 70% (230) only outpatient settings
    - 17% dental
    - 9% ambulatory surgery
    - 9% urology
  - IP breaches in 68% HAI investigation
  - Device reprocessing breaches most common



ASC: Outbreaks and IP risks



- 2 ASC
- 17 M. fortuitum hip/knee SSI
  - 9 organ space
  - 5 deep
  - 3 superficial
- Symptoms 5-306 days after procedure
- WGS highly related
- Common surg tech assoc with cases

Ambulatory surgery center A	Ambulatory surgery center B
1. Absence of a water management plan 2. Inadequate cleaning and disinfection of the operating room (OR) between patients 3. Unsatisfactory terminal cleaning of the ORs and scrub sinks 4. Missed opportunities for hand hygiene 5. Non-compliance with the personal protective equipment policy, including failing to wear head and beard coverings in restricted areas 6. Lack of point-of-use treatment with enzymatic cleaner or failure to leave instruments in an open position after use	1. Improper disposal of medical waste in the OR 2. Missed opportunities for hand hygiene 3. Inconsistent operation of the surgical helmet system and non-compliance with the manufacturer's instructions for use 4. Failure to conduct point-of-use treatment for surgical instruments after use in the OR and failure to keep instruments moist during transport to the sterile processing department

Godwin S et al. Infection Control & Hospital Epidemiology. 2025;46(12):1215-1221. doi:10.1017/ice.2025.10308

Source of CLABSI on Admission

Characterizing Patients Presenting on Hospital Admission with Central Line-Associated Bloodstream Infections: A Multicenter Study

Oladapo-Shittu et al., 2024 | *Clinical Infectious Diseases*

IDSA Infectious Diseases Society of America

BACKGROUND

We sought to characterize patients presenting to hospitals with central line-associated bloodstream infections (CLABSI-POA) in patients maintaining central venous catheters (CVCs) outside acute care hospitals.

POPULATION AND METHODS

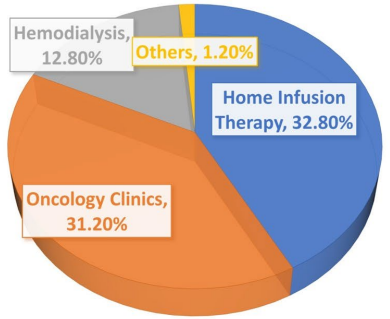
- Retrospective cross-sectional analysis of patients with CLABSI-POA in 3 health systems covering 11 hospitals over 1 year
- Cox proportional hazard analysis was used to assess factors associated with mortality.

RESULTS

461 patients were identified with CLABSI-POA

11% of patients died during hospital admission

Pre-admission categories of CVC maintenance



25% of patients with CLABSI-POA had had CLABSI in the past

- Enterobacterales were the most common etiologic agent (29%)
- Mortality risk increased with age, and with lack of insurance.
- Mortality risk decreased with CVC removal.

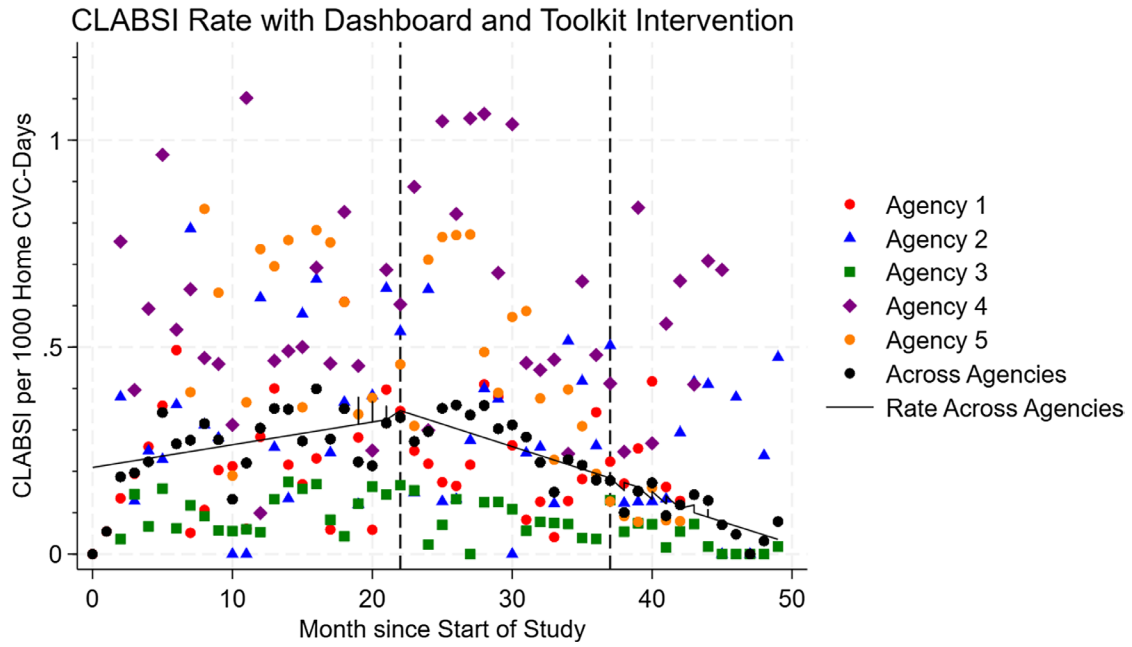
CONCLUSION

CLABSI-POA is associated with significant in-hospital mortality. Surveillance and targeted prevention initiatives are needed outside acute care settings.

Clinical Infectious Diseases https://doi.org/10.1093/cid/ciae144

Central lines, home infusion and “out of hospital” bloodstream IP

- Home infusion CLABSI 0.2-0.24/1000 CVC days
- Standard dashboard and prevention toolkit



Hannum S et al. Infect Control Hosp Epidemiol. 2026 Jan 21:1-8. doi: 10.1017/ice.2025.10385. Epub ahead of print. PMID: 41560365.

Topic	Available via written document	Available via video
Home infusion overview for all home infusion patients and introduction to IV lines	x	X
Equipment considerations for general home infusion patients	X	
Bathing with an intravenous line		X
Intravenous push medications	X	X
Elastomeric device medications	X	X
Electronic pump medications	X	X
Taking down chemotherapy	X	X
Parenteral nutrition	X	X
Changing an inotropic medication bag	X	
Using flow regulator medications	X	X
Using gravity flow medications	X	X
Medication bag with vial	X	X
Flushing ports		X
Flushing the unused side of IV	X	X
Adding medication to elastomeric device	X	X
Drawing a medication from a vial or ampule	X	X
Lock therapy	X	
Chlorhexidine bathing	X	
Considerations for patients at high risk of CLABSI	X	
Evaluation of a patient who has experienced a CLABSI	X	
Saline-administer-saline or saline-administer-saline-heparin cognitive aid	X	
Nursing competency assessment	X	
Site care algorithm	X	
Patient-directed dressing bundle	X	
Hand hygiene	X	

Barriers to out of hospital IP

Scope

- Number of sites
- Geographic spread
- Pace of growth
- Evolution of services

Fragmented ownership

- Variable oversight/leadership
- Contracted/outsourced services

Weak measurement and feedback

- Lack of standardized outpatient HAI metrics and denominators
- Infections often detected later at a different facility

Lean staffing and turnover

- Limited dedicated infection prevention coverage and training
- Variable (often limited) onboarding and competency validation

Workflow and space constraints

- High throughput and rapid room turnover pressures
- Clean/dirty separation and storage space constrained

High complexity tasks

- HLD/sterilization and device care are unforgiving processes

Environmental variability

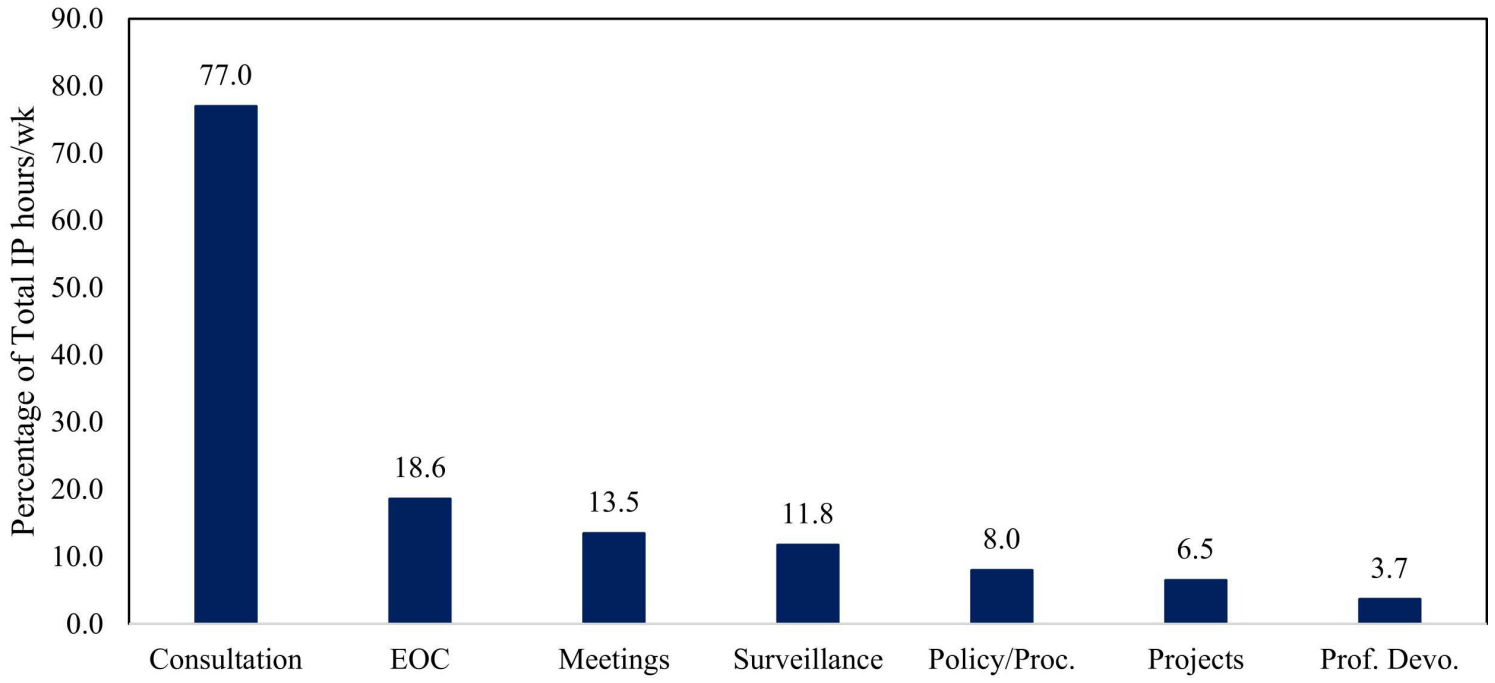
- Uncontrolled environments and caregiver dependent care

Culture/ Communication

- “It’s not a hospital” mindset
- Unreliable reach of updates/education

Determining IP staffing needs: Peds ambulatory/procedural

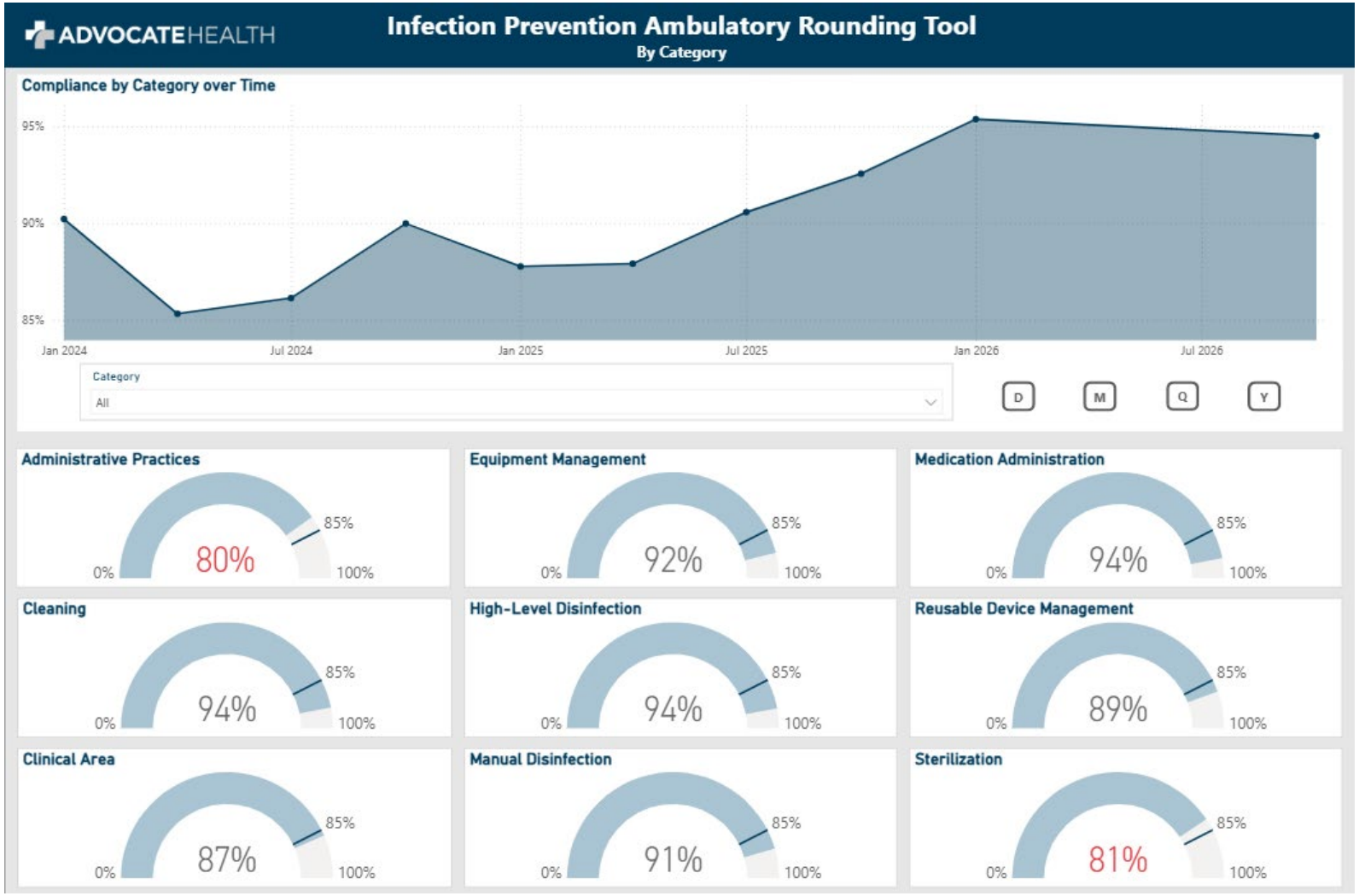
- 238 sites
  - 21% with surgical procedures
  - 32% AGP
- 80% outside of main hospital campus
- Survey Ips who cover ambulatory for complexity and hours per week engaged in IP activities
- 50% at least 1 complexity indicator, 9% 3 or more
- 181 hours/week
- 4.5 FTE needed for the surveyed sites
- Recommend assessing complexity, scope and service volume to determine staffing



Weir Lk et al. Determining infection prevention staffing needs for the pediatric ambulatory and procedural care setting. Am J Infect Control. 2025 Jan;53(1):8-12. doi: 10.1016/j.ajic.2024.08.011.

Health System Approach

- 2800+ Clinics
- Dedicated IP team: 14 IPs, 3.5 SPD specialists
- ~9% of clinics performing sterilization
- ~11% HLD
- Risk tiering
- Enterprise Ambulatory Rounding Tool
- Dashboard development



Heisner K et al. Infect Control Hosp Epidemiol. 2025 Jan 27:1-3. doi: 10.1017/ice.2024.232.

Antimicrobial Stewardship!!

PRIMARY CARE

Audit & feedback works

Meta-analysis of 56 RCTs: audit & feedback linked to lower antibiotic volume and better appropriateness.

~11% relative reduction in total volume; fewer unnecessary starts and broad-spectrum use.

Xu et al. Clinical Infectious Diseases (2025)

URGENT CARE

Short-course defaults (Take 5 Campaign)

Campaign increased adoption of guideline-concordant ≤5-day durations (11% increase).

Duration is a high-leverage stewardship target in walk-in settings.

Jenkins et al. Open Forum Infectious Diseases (2025)

PRIMARY CARE

Feedback beats clinical decision support system (CDSS)

Cluster RCT: feedback visit vs CDSS + feedback vs control

4.4% decrease in CDSS+feedback compard to control

No difference between feedback alone and control

Jeanmougin et al. J Med Internet Res (2024)

TELEMEDICINE

Tele-stewardship is maturing

Describe adapting outpatient stewardship core elements to telemedicine workflows.

Telemedicine can reduct antibiotic use but effects in outpatient settings are variable

Sanchez et al. Telemed E-Health (2024), Laein et al. PLoS One (2025)

PRIMARY CARE

Peer comparison "spillover"

Mailed peer-comparison feedback reduced prescriptions across all ages, not just the targeted group.

Also reduced prolonged courses (>7 days).

Saqib et al. JAMA Network Open (2025)

Primary Care/Urgent Care

Order sets help, but may not be enough

Order-set + awareness campaign shifted CABP therapy patterns.

No overall improvement in guideline concordance → need stronger tactics (Audit and feedback, defaults, follow-up).

Asempa et al. ASHE (2025)

SHEA Town Hall: Emerging Issues in Ambulatory Infection Prevention

February 17, 2026

Rebecca Stern, MD
Medical Director of Adult Ambulatory Infection Prevention

VANDERBILT UNIVERSITY
MEDICAL CENTER

Infectious Diseases

Disclosures

- No financial conflicts of interest

Shift from inpatient to ambulatory care

Key drivers

- Chronic care, aging population
- Evolving procedural technologies, e.g., minimally invasive, same-day
- Lower cost
- Fewer resources
- Health systems investing

Evolving landscape

- Clinics
- Ambulatory surgery centers (ASC) and office-based
- Infusion centers
- Hemodialysis
- Home care
- Academic vs. community health systems

Inpatient ≠ outpatient

High priority gaps and opportunities

Regulatory (Joint Commission)

- Variable facility licensing and accreditation
- Citations for noncompliance (standards, mIFU) increasingly concentrated in ambulatory
- Align mIFU policies/practices with inpatient

Healthcare-associated infections (HAI)

- Ambulatory reporting not required
- Lack validated definitions (except CLABSI in home infusion; pediatric CLABSI extrapolation from SPS)
- Surveillance / capture of denominators, across healthcare systems; benchmarks?
- Incentives?

ASCs

- SSI outpatient procedure component of NHSN is voluntary for most states, not applicable to all ASCs

- **Limited ambulatory-specific guidance by professional societies**
- **Challenges funding (FTE), under-resourced ($, HCW, IP)**

High level disinfection, sterilization

- Often decentralized
- Challenges to standardize, educate, and scale instrument reprocessing
- Single use device vs. environmental harms

Communicable disease / isolation + PPE

- Declining vaccination rates
- Exposure/outbreak tracking across health settings, EMRs
- Lack negative pressure rooms (measles, TB)
- Variable resource availability and practices for RVI
- Confusion re: MDR/CRE/XDR, C auris in clinics

- **Risk assessments**
- **Advocate for investment in ambulatory IPC**
- **Develop national network for shared resources, strategies**
  - **SHEA Ambulatory Interest Group**
  - **"Call to action"**

VUMC highlight: ambulatory COVID-19 transmission-based precautions

Infect Control Hosp Epidemiol. 2025 Sep;46(9):959-960. doi: 10.1017/ice.2025.84.
Epub 2025 May 16.

Isolating the burden of transmission-based precautions for COVID-19: walk-in clinic-based healthcare personnel perspectives

Rebe

The unintended burden of transmission-based precautions for suspected COVID-19 in the ambulatory setting

Rebecca A Stern [1,✉], Katherine Bashaw [2], Claude E Shackelford [3], Thomas R Talbot [1]

De-escalated ambulatory COVID-19 isolation requirement for contact component (gown/gloves)

- *Excludes bronchoscopy, AGPs*

- PPE guidance, education, sx check-in list to identify potential cases triggered Epic flag
- 60/197 (30.4%) required isolation, don/doff added 2.15 min for avg. 1.8x
  - **Added 3.9 min per patient encounter requiring PPE --> 1.3 hrs daily**
- Perceived challenges: HCW burden, workflow impediment, specimen handling, waste
- PPE access is imperative

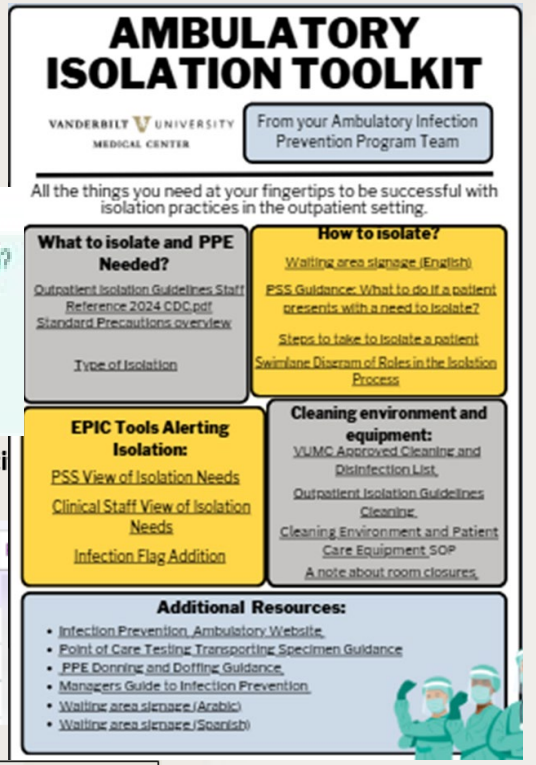
VUMC ambulatory isolation guidance

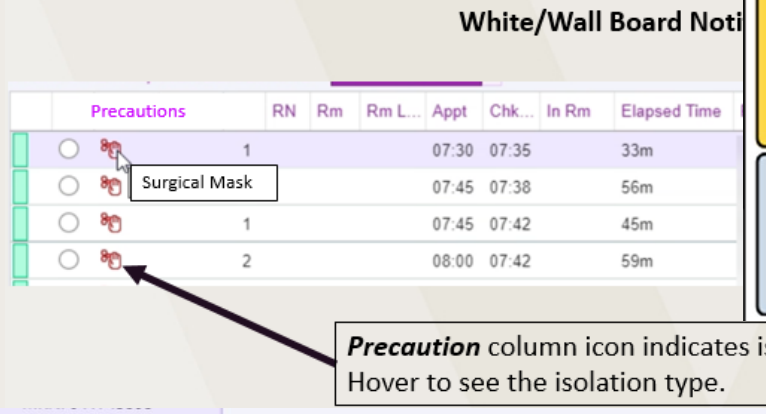
- Phased rollout
- Refined communicable disease screening tool for MHAV & check-in; BPAs incorporated

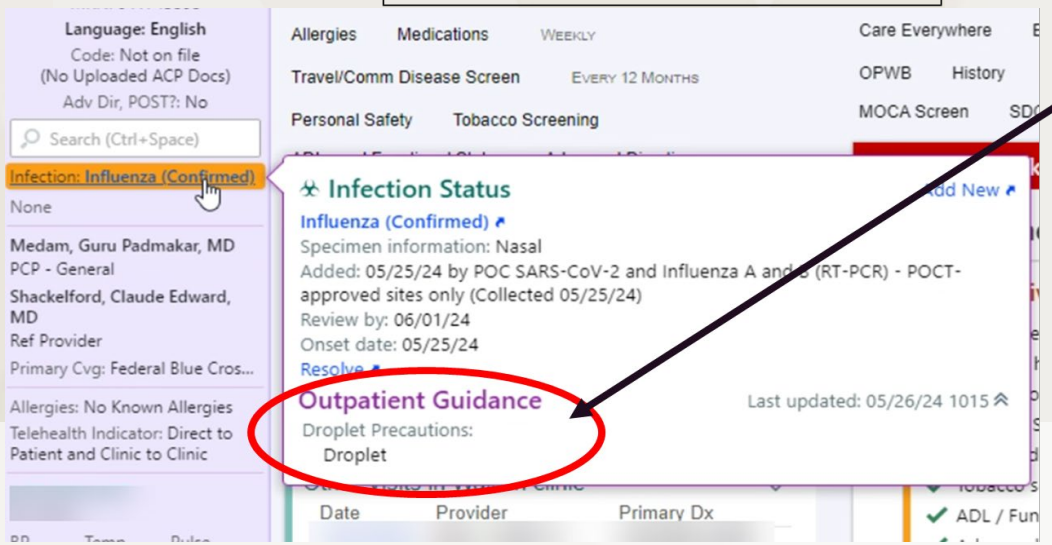
Outpatient Isolation Guidelines 2025

Condition	Airborne (N95)	Contact (Gown & Gloves)	Droplet (Surgical Mask)	Eye Protection (Face Shield/Goggles)	Environmental Cleaning *Know contact time	Additional precautions
Known or Suspected Infections (Infection Flag)						
Adenovirus		X	X		Super Sani Wipes	
Clostridium difficile (C. diff)		X			Bleach Wipes	Use **Soap and Water** for Hand Hygiene after leaving the exam room.
COVID-19	X			X	Super Sani Wipes	
Cystic Fibrosis		X			Super Sani Wipes	
Gastroenteritis (e.g. Rotavirus)		X			Super Sani Wipes	
Influenza			X		Super Sani Wipes	
Measles (Rubeola)	X				Super Sani Wipes	**Room closed** for 1 hour after patient leaves for air exchanges.
Metapneumovirus		X				
Mpox	X	X		X	Super Sani Wipes	
Mumps			X		Super Sani Wipes	
Neisseria meningitidis			X		Super Sani Wipes	
Norovirus		X			Bleach Wipes	Use **Soap and Water** for Hand Hygiene after leaving the exam room.
Parainfluenza		X			Super Sani Wipes	
Parvovirus B-19			X		Super Sani Wipes	
Pertussis			X		Super Sani Wipes	
RSV		X			Super Sani Wipes	
Rubella			X		Super Sani Wipes	
Tuberculosis - Pulmonary	X				Super Sani Wipes	**Room closed** for 1 hour after patient leaves for air exchanges.
Varicella	X	X			Super Sani Wipes	**Room closed** for 1 hour after patient leaves for air exchanges.
Shingles	X	X			Super Sani Wipes	**If disseminated or immunocompromised, as indicated by the provider. Room closed** for 1 hour after patient leaves for air exchanges.
Viral Conjunctivitis		X			Super Sani Wipes	

Updated:4/16/2025







VUMC highlight: PRP (platelet-rich plasma)

Infection Control & Hospital Epidemiology (2026), **47**, 1–5
doi:10.1017/ice.2025.10316

SHEA

Original Article

Platelet-rich plasma therapy: key infection prevention practices and strategies for safety risk reduction

Rebecca A. Stern MD[1], Jennifer Andrews MD[2,3], Katherine Bashaw MHA, LPN[4] and Thomas R. Talbot MD, MPH[1]

EOC survey by IP identified high-risk procedure

- Large scope
- No professional society guidance
- Variable application and techniques

Developed standardized approach to best practices, implementation

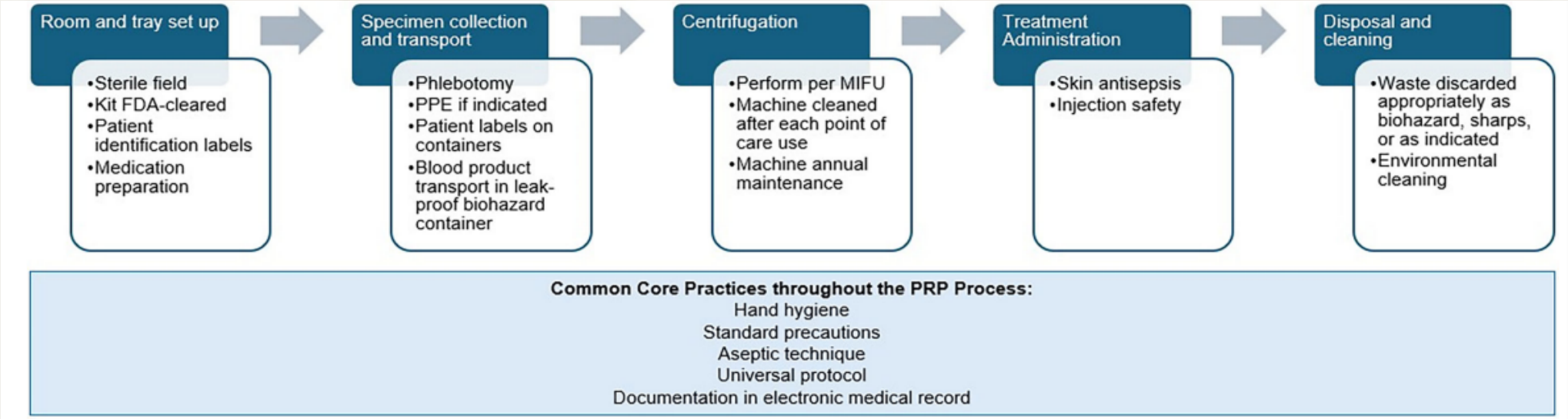


Figure 1. Process flow and key expected steps in the PRP process. Abbreviations: FDA, Food and Drug Administration; PPE, personal protective equipment; MIFU, Manufacturer Instructions for Use.

Interested? Join the SHEA Ambulatory Special Interest Group:

- Email kweinshel@shea-online.org
- Next meeting: 3/11 @ 3 pm ET

Thank you!

Rebecca.stern@vumc.org

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