



Trouble Getting Infection Prevention Support?

*why infection prevention struggles to get
support and how to fix it*

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What is your goal?

- Staff
 - ROI vs system/ hospital priorities
 - Assess
 - New capabilities
 - Resolve citations or deficiencies
 - Requests from other departments
 - Consult the APIC calculator, Vizient or other consultant staffing models
- Tools
 - Particulate counters, ATP testers, computers, software, borescope, etc.
 - Often, the equipment is a minor cost to the cost of staff time, consumables, and maintenance
 - Careful to push for cost other departments have to maintenance or staff

Assess Resources:

Leaders' Point of View

- Assess current scores:
 - Star ratings
 - Leapfrog, TJC, CMS Hospital Quality Initiative (Hospital Compare), US News, Healthgrades
 - Other quality evaluation metrics (Vizient, Kaufman Hall, Fortune/IBM Watson Health [Merative], IQVIA, Optum, Medidata, Oracle)
- Assess finances:
 - Often hard to get solid information, but watch the signs

Downsizing or Department Limitations

- Eventually, most leaders in IP will reach a stage where cost-cutting is mandated or growth occurs without additional staff.
 - Consider:
 - Travel budget, contracts for software, equipment maintenance, other discretionary spending
 - For outbreaks, assess whether for other department budgets that can be charged
 - Track key services done now and what may have to be cut or abbreviated
 - Survey readiness, audits, rounding
 - In-person staff training vs video
 - What can be automated to decrease staff time?
- Track it! Make note of pushback from other departments or med staff.

Financial Headwinds

Budget Forecast — Cloudy with rain likely

Economic challenges
expected through 2026 and 2027



The pendulum swings! Things will get better!

- ✓ Rural Transformation dollars
- ✓ Shift from inpatient to outpatient
- ✓ Ambulatory Surgery Centers
- ✓ Pharmacy 340B/Infusion centers
- ✓ Value-Based Care like TEAMS, CJR-X
(Comprehensive Care for Joint Replacement Expanded) Model



PARKVIEW



CMS.gov / Innovation Center

CJR-X is here.

MANDATORY JOINT REPLACEMENT BUNDLES, EXPANDED.

Full episode accountability across the 90-day window.
The infrastructure to manage it is already built.



Anticipated to be operational by October of 2027



Plan Your ROI Discussion

- Cost savings:
 - Leaders will want to know what has been considered and the pros/cons.
 - 25-30% of the CMS value-based purchasing is related to IP and holds a 2% payment reduction.
 - 75% of the CMS HAC penalty program is related to IP and holds a 1% payment reduction
- What do your partners in other departments think (facilities, pharmacy, lab, nursing, EVS, Occ Health, etc.)? Seek support and develop a common message.
 - Lab and IS can often limit the speed and pace of change.

Success is often found when your suggestion can fix one of their problems.

Clinical Value

- How will your change improve clinical care?
 - Muster support from other collaborating departments
 - Assess realistically, how the change will be implemented and long-term commitments
 - Work with your immediate leaders to develop a business plan/operational plan to submit to their leaders.
 - 2-minute elevator speech and 1 page summary even if there is a 10- or 20-page ROI document with details.

EMR with Specialized Infection Prevention/Stewardship

- Business case may be better defined for stewardship than IP
 - Easier to estimate hard dollars
 - Soft dollars carry less weight
- Leverage EMR IP solution to for efficiency and lower staff cost
- Improving clinical safety
- Streamline surveillance
- Decrease turn-around time
- Reduce manual reporting

EMR challenges

- Assess the current version
 - Assess the functionality of the EMR vs what your system has built/turned on.
 - Check with your IS builder/report builder
- Does the software support the function/graph/chart or is there a problem with the current version or IS support?
- Validate new data streams
- Monitor for any new lab equipment
 - Technical limitations of the lab software or IS build might prevent that cool new feature from working as advertised.
 - Infection rates may look spectacular—until the lab results are added from new platform

Audience Question

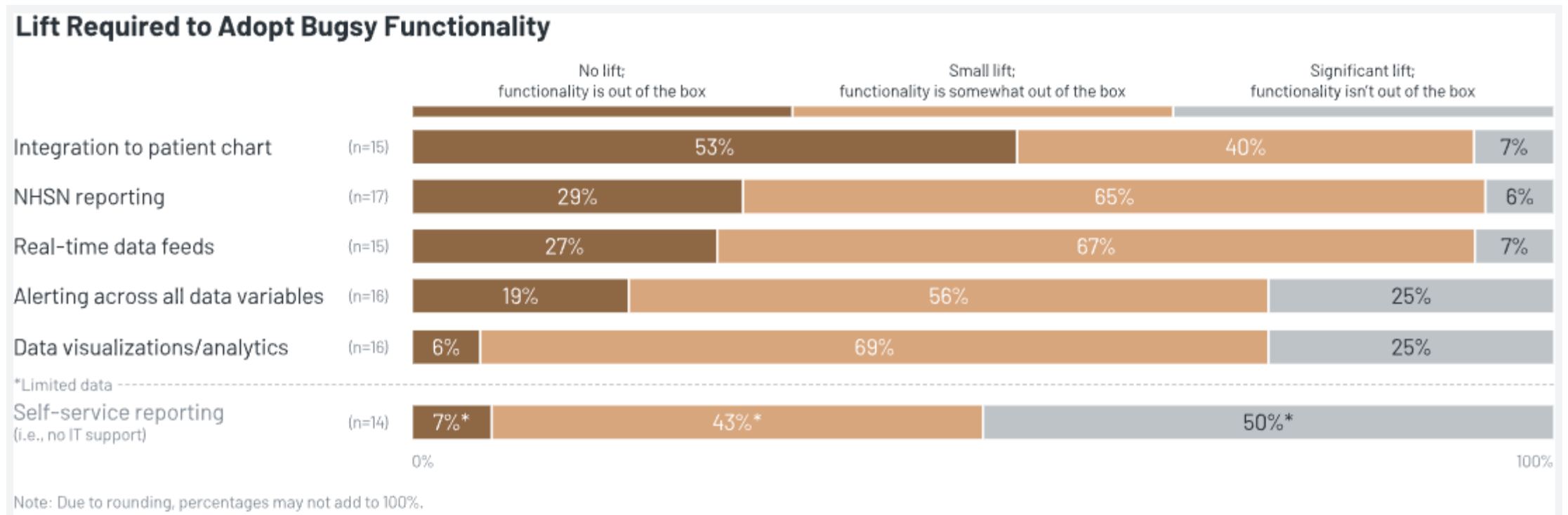
- By a show of hands, how many are using a single EMR solution for IP?
- By a show of hands, how many are using and additional vendor solution?
 - Wolters Kluwer (Sentri7)
 - VigiLanz
 - BD (HealthSight Infection Advisor)
 - Premier (Theradoc)

KLAS Research

- KLAS research reviewed EMR Infection Prevention Software based on user surveys.
- Key findings:
 - Best of breed
 - Vigilanz
 - Wolters Kluwer
 - Epic works, but will require work

EPIC Buggy 2026: Per Klas-research

Functionality out of the box—*“Time and strong internal support are often required to succeed with Buggy; one-third of respondents didn’t reach a successful state within 12 months.”* Note this was based on 14-16 responses.



Epic Connect

- Strong local support for 1st and 2nd level support
- Local vs Epic-Verona support
- Out of the box functionality vs the build out
 - Validate data feeds
 - IS/Lab support
 - Long term analysis and cadence
- Support from Epidemiologists, Data Analysts, Buggy builders and Business Intelligence may be needed.

It's about the Data!

- “He who controls the data is king”
- IP and Quality have access to a lot of data
- Key uses:
 - Inform leadership decision making
 - Drive information to providers to change provider culture and habits
 - Can help predict where problems may arise
- Workforce optimization
 - Saving Quality dollars
- Improved throughput and decreased length of stay (LOS)

These are key drivers!

Hospital 1 CMS Value Based Events

Event	# of Events (2024 Final)	# of Events (2025 YTD)	SIR (2024 Final)	SIR (2025 YTD)
CLABSI	0	0	0.000	0.000
CAUTI	0	0	0.000	0.000
SSI – COLO*	0	0	0.000	0.000
SSI – HYST*	0	0	0.000	0.000
HO C. diff**	2	6	1.058	2.344
HO MRSA bacteremia**	1	0	6.494	0.000

*CMS only includes deep/organ space SSI in their Value Based Events/SIR

**LabID SIR is updated quarterly

Hospital 2 - CMS Value Based Events

Event	# of Events (2024 Final)	# of Events (2025 YTD)	SIR (2024 Final)	SIR (2025 YTD)
CLABSI	0	0	0.000	0.000
CAUTI	0	0	0.000	0.000
SSI – COLO*	0	0	0.000	0.000
SSI – HYST*	0	0	0.000	0.000
HO C. diff**	2	1	1.693	1.087
HO MRSA bacteremia**	0	0	0.000	0.000

*CMS only includes deep/organ space SSI in their Value Based Events/SIR

**LabID SIR is updated quarterly

CAUTI

(Catheter Associated Urinary Track Infections)

Show Total

CAUTI

CAUTI

Start Date (mm/dd/yyyy)

12/1/24

End Date (mm/dd/yyyy)

11/30/25

Date Level

Month

Hospital Location

(Multiple values)

Departments

(All)

Split for Location Comparison

(select specific locations above)

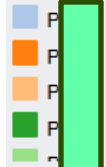
Split Locations

Yes

Split Departments

No

Color Split

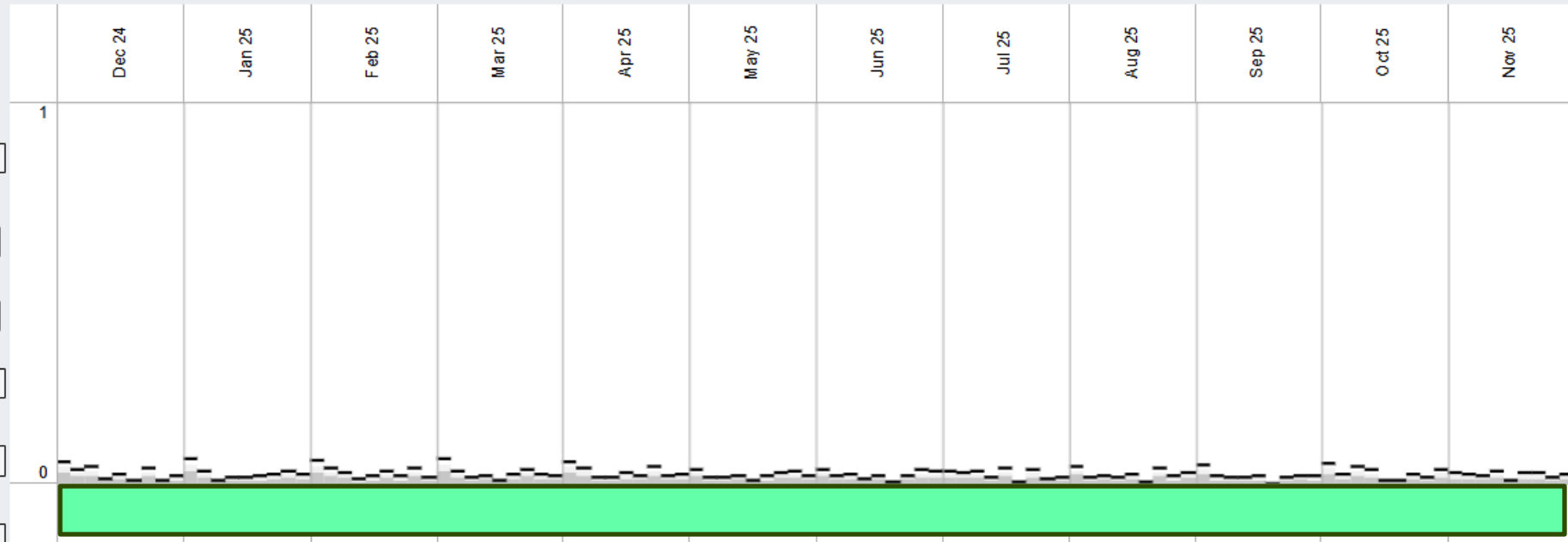


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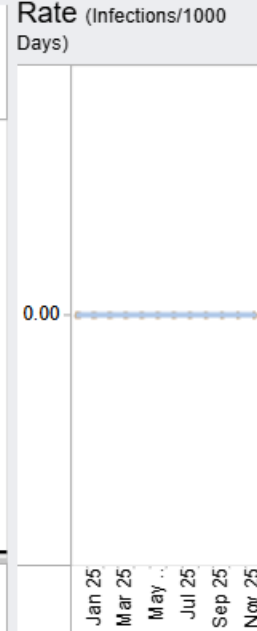


Most Recent Data: Nov 2025

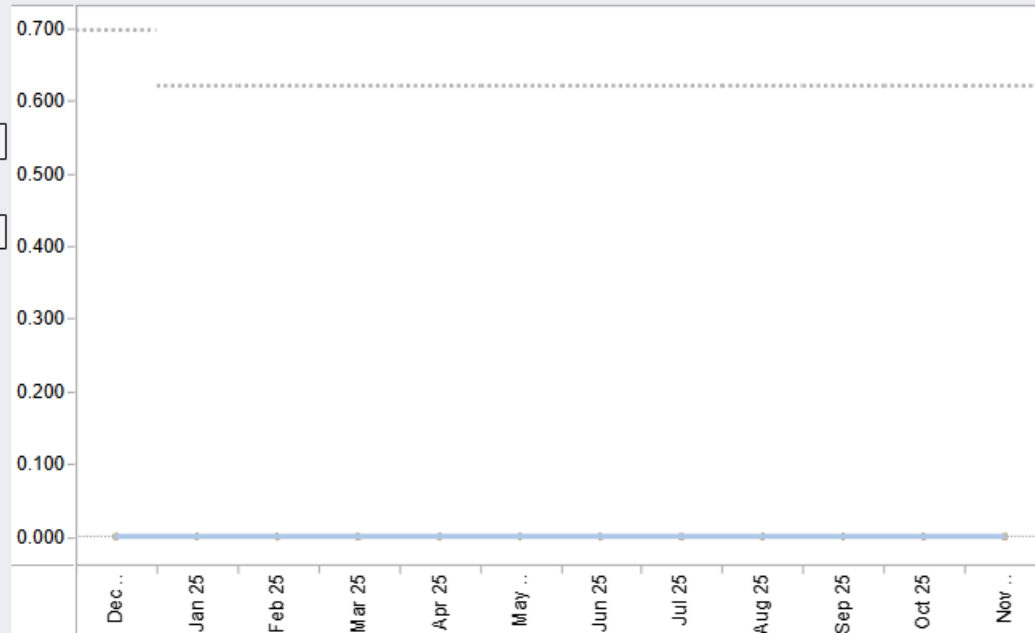
Infection Count Observed vs Predicted (shaded areas 50, 75 percent of predicted)



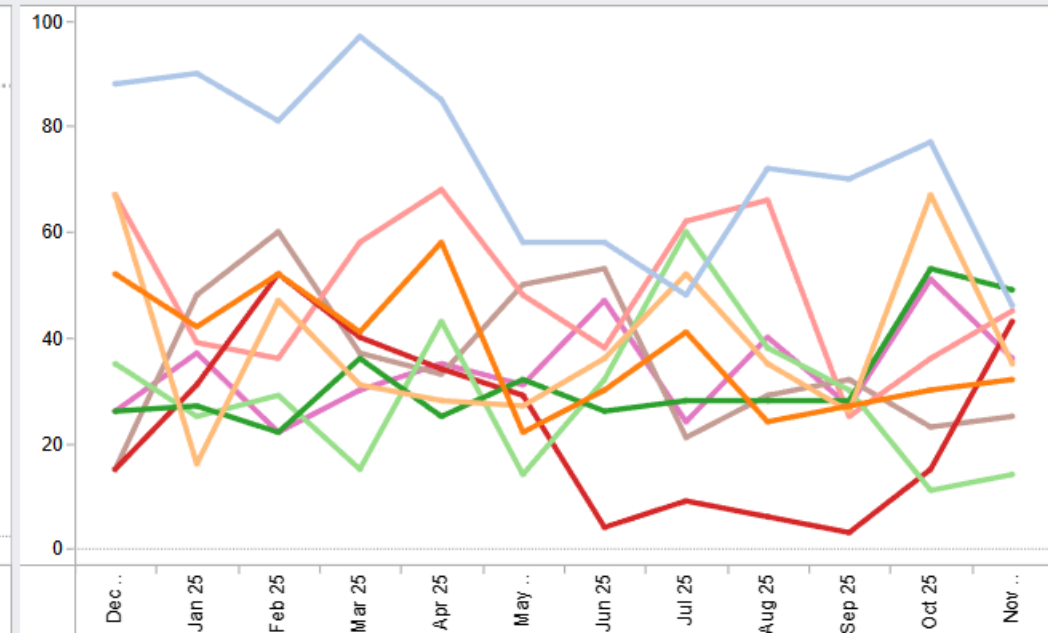
CAUTI - Monthly Rate (Infections/1000 Days)



CAUTI - Monthly SIR (Observed/Predicted Infections)



Catheter Days



CLABSI

(Central Line Associated Blood Stream Infections)

Show Total

CLABSI

CLABSI

Start Date (mm/dd/yyyy)

12/1/24

End Date (mm/dd/yyyy)

11/30/25

Date Level

Month

Hospital Location

(Multiple values)

Departments

(All)

Split for Location Comparison

(select specific locations above)

Split Locations

Yes

Split Departments

No

Color Split

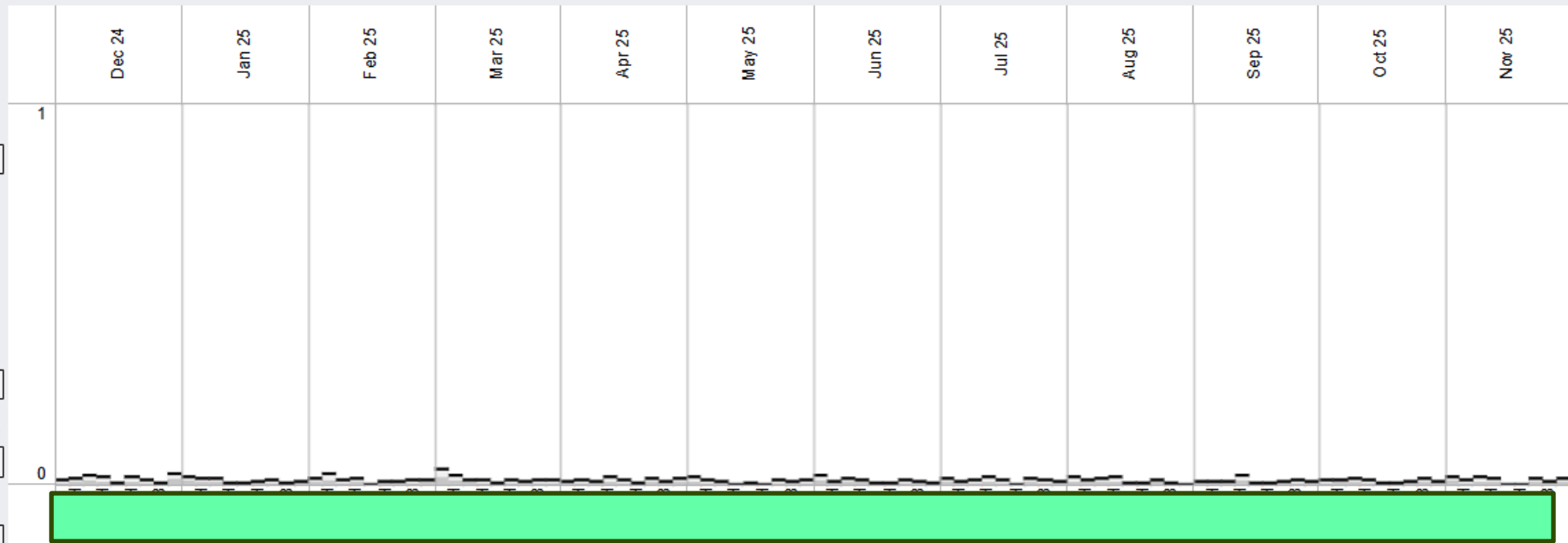


Powered By

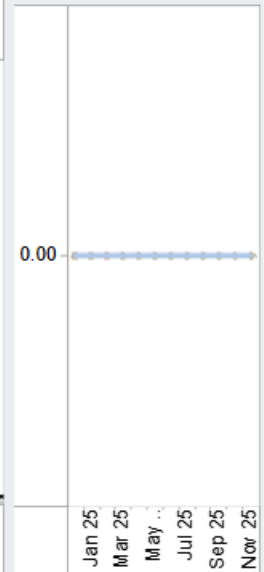


Most Recent Data: Nov 2025

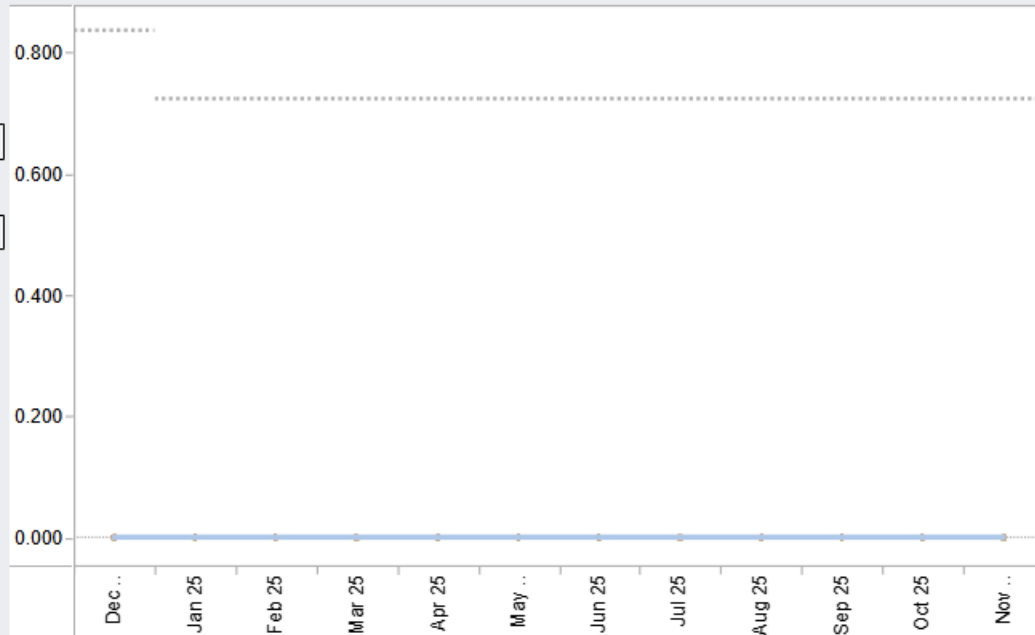
Infection Count Observed vs Predicted (shaded areas 50, 75 percent of predicted)



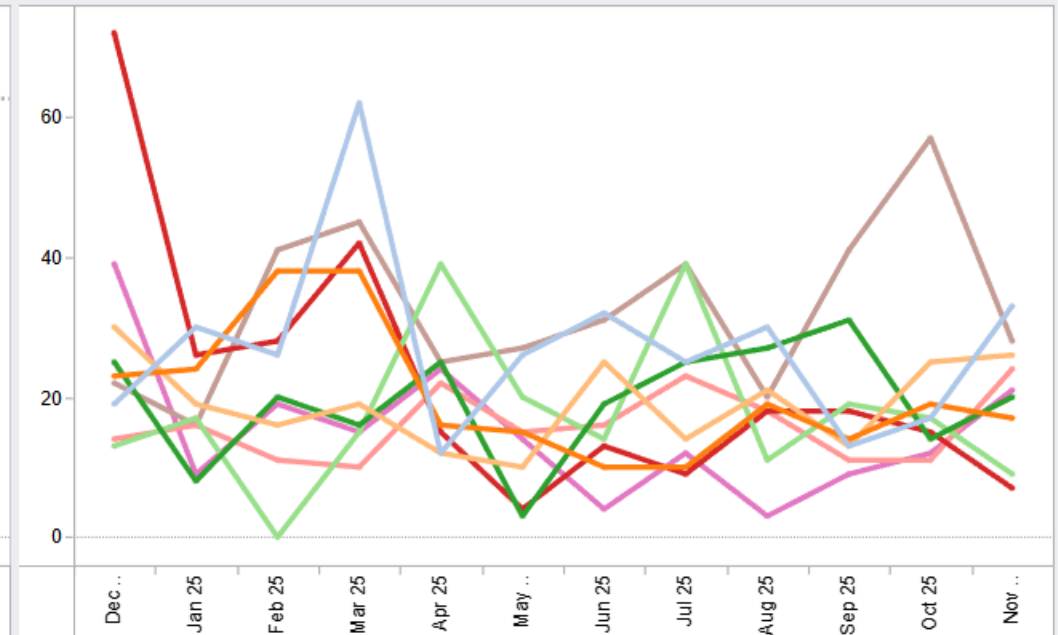
CLABSI - Monthly Rate (Infections/1000 Days)



CLABSI - Monthly SIR (Observed/Predicted Infections)



Line Days



Elevated Syndromes By

Percent Above Average

Threshold 20

7

Occurrences Above Average

Threshold 5

6

Z-Score

Threshold 1.5

1

Normalized Score

Threshold 80

1

Top 10 Syndromes by Percent Above Average

Syndrome	Last 30 Days	% Above Average	Feb 2024 through Dec 2025	Dec 2025	Jan 2026
Influenza A	3,784	+201%		3,103 ↗	1,175
COVID	2,366	+145%		2,074 ↗	879
Influenza B	778	+112%		588 ↗	311
RSV	270	+99%		176 ↗	137
Invasive Haemophilus Influenzae	2	+43%		2	0
Norovirus	27	+42%		31 ↗	6
Blastomycosis	1	+25%		0	1
Gonorrhea	27	+17%		26 ↗	16
ESBL	140	+9%		160 ↗	47
Clostridioides difficile	105	+2%		124 ↗	32

Top 10 Syndromes by Occurrences Above Average

Syndrome	Last 30 Days	+/- Above Average	Feb 2024 through Dec 2025	Dec 2025	Jan 2026
Influenza A	3,784	+2,528		3,103 ↗	1,175
COVID	2,366	+1,400		2,074 ↗	879
Influenza B	778	+411		588 ↗	311
RSV	270	+134		176 ↗	137
ESBL	140	+11		160 ↗	47
Norovirus	27	+8		31 ↗	6
Gonorrhea	27	+4		26 ↗	16
Clostridioides difficile	105	+2		124 ↗	32
Invasive Haemophilus Influenzae	2	+0.6		2	0
Blastomycosis	1	+0.2		0	1

Top 10 Syndromes by Z-Score

The z-score is the number of standard deviations above average.

Syndrome	Last 30 Days	Z-Score	Feb 2024 through Dec 2025	Dec 2025	Jan 2026
COVID	2,366	1.76		2,074 ↗	879
Influenza A	3,784	1.06		3,103 ↗	1,175
Norovirus	27	0.83		31 ↗	6
RSV	270	0.62		176 ↗	137
Influenza B	778	0.60		588 ↗	311
Gonorrhea	27	0.59		26 ↗	16
ESBL	140	0.49		160 ↗	47
Invasive Haemophilus Influenzae	2	0.43		2	0
Blastomycosis	1	0.26		0	1
Clostridioides difficile	105	0.13		124 ↗	32

Top 10 Syndromes by Normalized Score

Normalized score assigns each syndrome a score from 0 to 100 based on how the current count compares to the historical minimum and maximum.

Syndrome	Last 30 Days	Normalized Score	Feb 2024 through Dec 2025	Dec 2025	Jan 2026
COVID	2,366	81		2,074 ↗	879
Gonorrhea	27	57		26 ↗	16
ESBL	140	54		160 ↗	47
Norovirus	27	53		31 ↗	6
Clostridioides difficile	105	49		124 ↗	32
MRSA	136	44		147 ↗	50
Influenza A	3,784	37		3,103 ↗	1,175
Serratia Marcescens	29	37		33 ↗	12
Streptococcus pneumoniae	17	36		15	10
Rhinovirus/Enterovirus	25	33		39	6
Invasive Haemophilus Influenzae	2	33		2	0
Blastomycosis	1	33		0	1

Streptococcus pneumoniae 2-year trend

Overview

[View Streptococcus pneumoniae configuration](#)

17 Last 30 Days

+0% Above Average

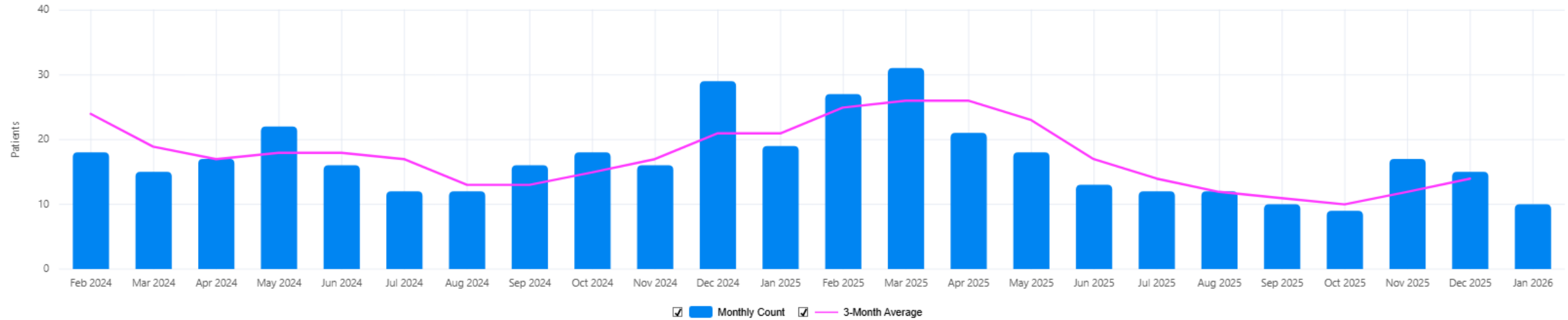
+0 +/- Above Average

-0.03 Z-Score

36 Normalized Score

Trends

Display Mode **Rolling Average** Control Chart



Postal Codes

Postal Code	City	Last 30 Days	Feb 2024 through Dec 2025	Nov 2025	Dec 2025	Jan 2026
		2		1	1	1
		1		0	0	1
		1		0	0	1
		1		0	0	1
		1		1	0	1
		1		0	0	1
		1		0	1	0
		1		0	1	0
		1		1	1	1

Only showing the 15 postal codes with the most patients.

Departments

Department	Last 30 Days	Feb 2024 through Dec 2025	Nov 2025	Dec 2025	Jan 2026
	2		0	1	1
	2		0	2	0
	1		0	0	1
	1		0	1	0
	1		1	0	1
	1		2	1	1
	1		0	1	0
	1		0	0	1
	1		0	1	1

Only showing the 15 departments with the most patients.

UTI Antibiotic Dashboard

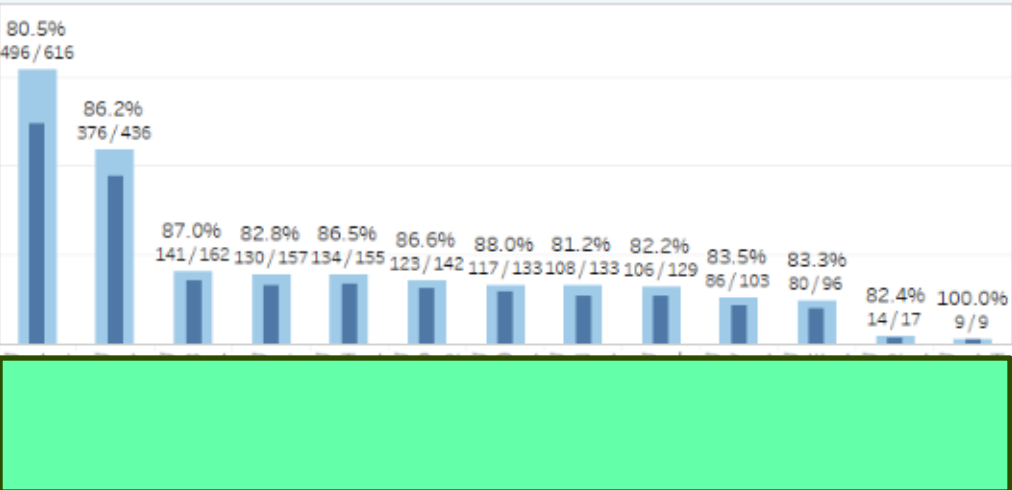
Last refresh: 3/18/2026 7:17:31 AM
Data as of: 2/28/2026

Powered By **PARKVIEW** Business Intelligence

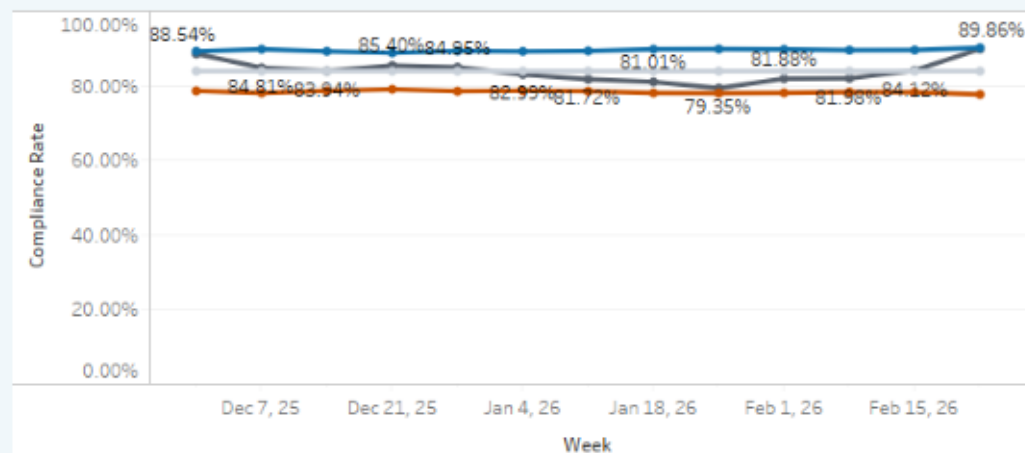
EncounterType: |
 Month, Year of Activity: |
 Facility: |
 Specialty: |
 Patient Age (bin): |
 Min prescription per provider:

Control Chart Legend: Average Rate, Lower Bound, Upper Bound, Rate
 Compliance Rate Legend: Cases w/ Antibiotics, Compliant

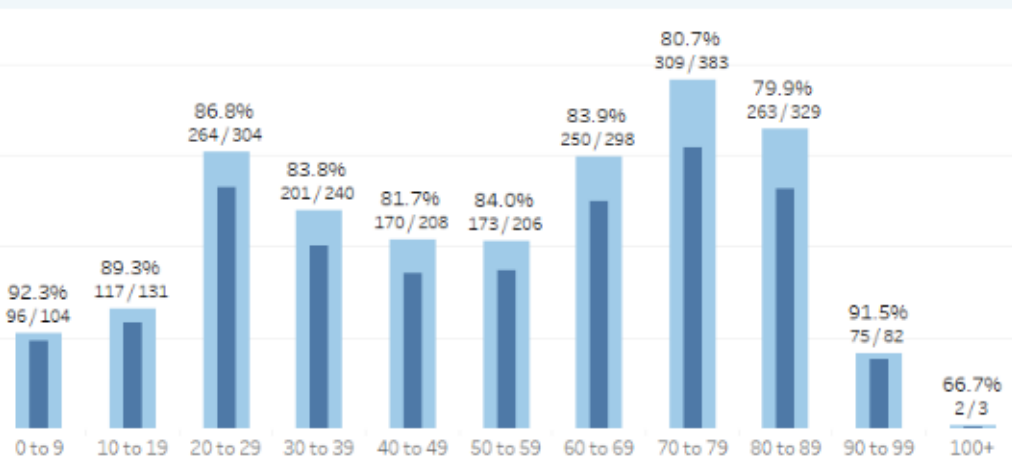
ED UTI Antibiotic Compliance Rate By Facility



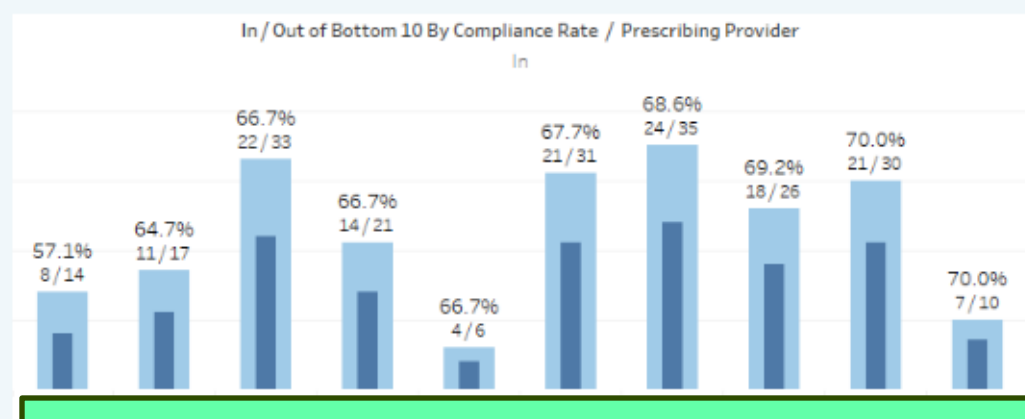
ED UTI Antibiotic Compliance Weekly Control Chart



ED UTI Antibiotic Compliance Rate By Age Group



ED UTI Antibiotic Compliance Rate - Bottom 10 Providers



UTI report for ED, last 3 months compliance to appropriate antibiotic and duration.

Drill down available.

NHSN Antimicrobial Use SAAR

Location

Start Date (mm/yyyy)

End Date (mm/yyyy)

For a list of antimicrobials included in each metric click here [➔](#)

If start date is left blank it will default to the most current 12 months of data



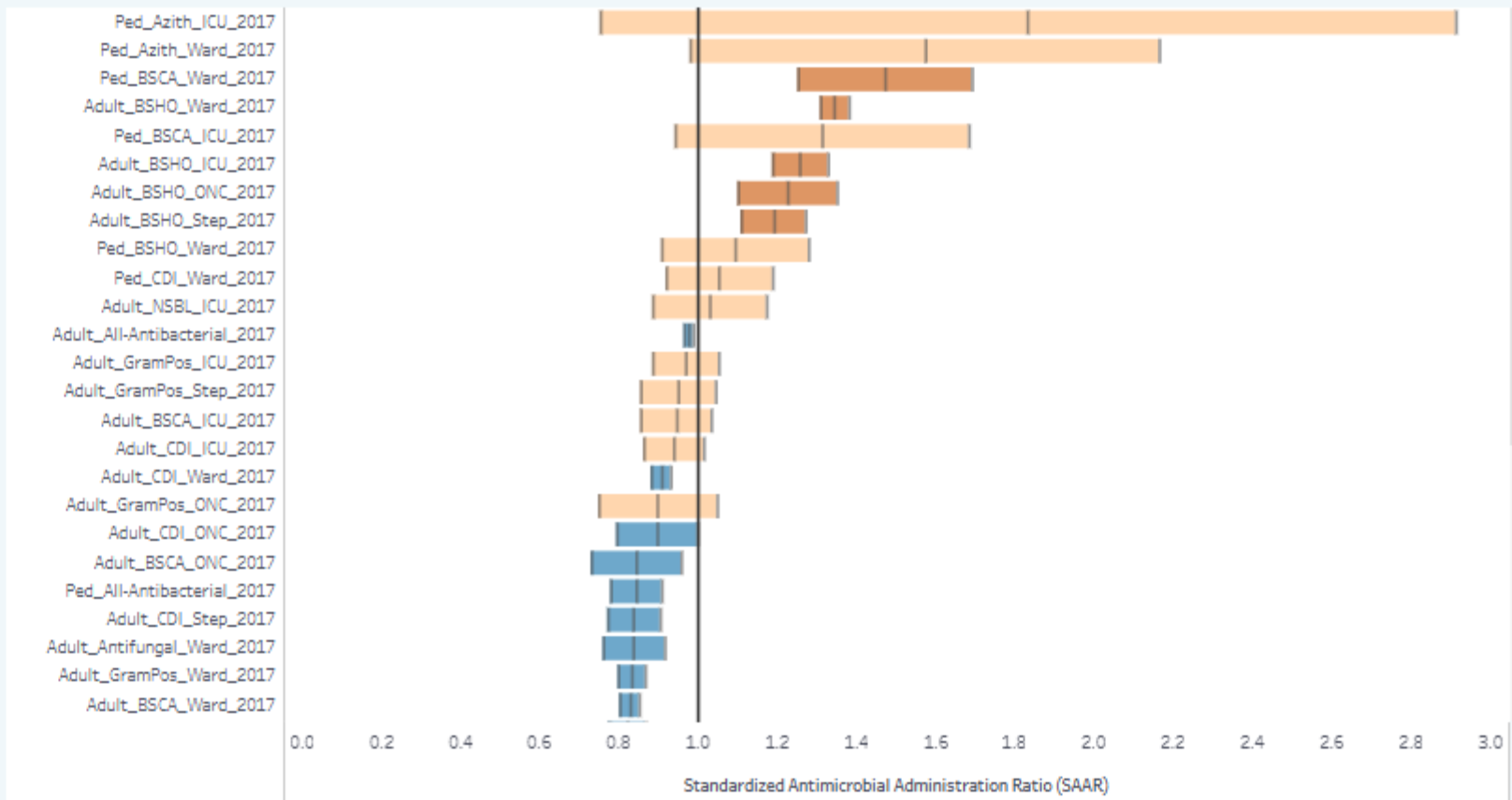
Estimated Performance by Metric

Using this Graph

The goal of the graph to the right is to highlight areas of strong and weak performance in antimicrobial stewardship. While the Standardized Antimicrobial Administration Ratio (SAAR) is an excellent starting point for this assessment, short periods of time, or metrics with a small number of Days Present are subject to high variation due to chance.

The center line on each bar is the SAAR for that metric for the given date range. The ends of the bar represent the highest and lowest estimate of Parkview's performance using a confidence interval of 95 percent.

To rephrase: without changes to internal process or a substantial shift in patient characteristics, we have 95 percent confidence future performance will lie within the given the range.



■ statistically better than predicted
 ■ statistically equivalent to predicted
 ■ statistically worse than predicted

THE NHSN STANDARDIZED RESISTANT INFECTION RATIO (SRIR) AND PATHOGEN- SPECIFIC STANDARDIZED INFECTION RATIO (pSIR)

A Guide to the SRIR and pSIR



NATIONAL HEALTHCARE SAFETY NETWORK
ANTIMICROBIAL RESISTANCE OPTION

Standardized Resistant Infection Ratio

Example SRIR interpretation

As an example, here is an interpretation of one row of a sample SRIR report for HO extended-spectrum cephalosporin-resistant Enterobacterales in urine specimens.

National Healthcare Safety Network
SRIR Table - All Standardized Resistant Infection Ratios (2019 Baseline)
 As of: September 7, 2023 at 5:33 PM
 Date Range: AR_ALL_SRIR_2019 summaryYr 2020 to 2022
 If (((SRIR_Type = "HO_ESCEall_Urine")))

Hospital-onset (HO) Extended-spectrum cephalosporin-resistant Enterobacterales in urine specimens

Facility Org ID	Summary Yr/Qtr	SRIR Type	Resistant Hospital-Onset Isolates	Predicted Resistant Hospital-Onset Isolates	Patient days from AR Summary	SRIR	SRIR p-value	95% Confidence Interval
13860	2020Q1	HO_ESCEall_Urine	0	0.339	7226	0.000	0.713	., 8.837
13860	2020Q3	HO_ESCEall_Urine	0	0.902	19208	.	.	.
13860	2020Q4	HO_ESCEall_Urine	0	0.170	3618	.	.	.
13860	2021Q2	HO_ESCEall_Urine	0	0.221	4700	.	.	.
13860	2021Q3	HO_ESCEall_Urine	0	0.615	13100	0.000	0.541	., 4.871
13860	2021Q4	HO_ESCEall_Urine	2	0.355	7550	5.634	0.056	0.945, 18.613

Note: This example uses fictitious data for illustrative purposes only.

TAP Reports

National Healthcare Safety Network

TAP Report for FACWIDEIN CDI LabID data for Acute Care and Critical Access Hospitals (2015 Baseline)

Facilities Ranked by CAD 'Cumulative Attributable Difference'

Cumulative Attributable Difference (CAD) Multiplier: Custom Value = 0.5

A TAP Report is the first step in the CDC TAP Strategy. For more information on the TAP strategy, please visit: <http://www.cdc.gov/hai/prevent/tap.html>

As of: December 22, 2023 at 6:41 PM

Date Range: BS2_CDI_TAP summaryYr 2021 to 2021



Facility Rank	Facility Org ID	Facility Name	State	Type of Facility	Type of Affiliation	Number of Beds	Patient Days	COHCFA Prevalence Rate	CDIF Facility Incident HO LabID Event Count	Number Predicted	Facility CAD	SIR	SIR Test
1	10018	DHQP MEMORIAL HOSPITAL	GA	HOSP-GEN	U	150	31000	0.00	8	11.822	2.09	0.677	
2	10273	HAWAII STATE HOSPITAL	HI	HOSP-PSYCH		20	8400	0.00	2	1.164	1.42	1.718	
3	10401	DHQP MEMORIAL ANNEX	GA	HOSP-GEN	M	225	12000	0.00	3	5.080	0.47	0.593	

1. This report includes facility-wide inpatient data from acute care hospitals for 2015 and forward.
2. Use the line list and frequency table output options to view location specific data. For instructions visit Output/Report Option types on the Analysis Quick Reference Guides page; <http://www.cdc.gov/nhsn/ps-analysis-resources/reference-guides.html>
3. Facility Rank = Priority ranking for Targeted Assessment of Prevention by CAD in descending order
4. COHCFA PREVALENCE RATE = Community-onset healthcare facility-associated CDI prevalence rate per 100 admissions
5. CAD = Observed - Predicted*SIR Goal
6. SIR is set to '.' when predicted number of events is <1.0. SIR TEST = 'SIG' means SIR > SIR Goal significantly

Source of aggregate data: 2015 NHSN CDI Data

Data contained in this report were last generated on December 22, 2023 at 1:27 PM to include data beginning January 2021 through December 2021 .

NHSN Antimicrobial Use - by Department

Location

Departments

Department Aggregation

Start Date (mm/yyyy)

End Date (mm/yyyy)

If start date is left blank it will default to the most current 12 months of data



Days Present



Antimicrobial Use (AU) Days



AU Rate (AU Days / Days Present * 1000)



All departments

Location Summary (select to filter)

	Sum of AU days	Days Present	AU / 1000 D
	18,801	88,282	213
	14,098	13,231	1,066
	10,530	15,472	681
	10,218	15,568	656
	10,172	15,776	645
	8,984	15,452	581
	8,750	10,398	842
	7,814	11,377	687
	7,057	10,009	705

Antimicrobial Summary (select to filter)

	Sum of AU days	Days Present	AU / 1000 D
PIPERWT	30,193	88,282	342
CEFTRX	21,085	88,282	239
CEFAZ	19,095	88,282	216
VANC	12,585	88,282	143
LNZ	7,684	88,282	87
METRO	7,578	88,282	86
MERO	7,395	88,282	84
AZITH	6,555	88,282	74
CEFEP	6,357	88,282	72
DOXY	4,813	88,282	55
LEVO	4,766	88,282	54
CEPHLX	3,851	88,282	44
AMOXWC	3,778	88,282	43
AMP	3,263	88,282	37

Excess Patient Days by Location: PRMC



Marketing Internally

- It has been said that IP is a team sport
- It is important to share with other department leaders
- Share the data with analysis—either directly or through your leaders

THE MEDICAL DIRECTOR AS AN ADVOCATE

Role of the Medical Director/ CMO

- Leadership strategic goals—1 yr and 5 yr
- Create Department Priorities
- Match Department needs to Priorities
- Seek Resources
- Assess Barriers
- Interface w/ Local and State Public Health
- Educate Medical Staff
- Support Interventions



What Else Can a Medical Director Do?

- Case reviews
- Assist IP's with current literature and interpretation
- Keep abreast of changes and recommendations
- Coordinate at the system level
- Public Health projects

How to Gain Support for Infection Prevention Departments

Leadership Priorities

- Patient safety & outcomes
- CMS penalties
- Public reporting
- Throughput & LOS

Bridging the Gap

- Translate nursing work into data-driven outcomes
- Partner across departments

Nursing Wins

- Reduce HAIs
- Standardize care
- Improve efficiency

Nursing Voice

- Frontline insight drives change
- Data + stories = advocacy





THANK YOU!

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