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SHEA

Commentary

Putting the "all" in "safe health care for all"

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Infection Control & Hospital Epidemiology (ICHE) was first published in 1980 under the title *Infection Control*. In an editorial that appeared in the inaugural issue, Richard Wenzel and William Schaffner described the then-current state of knowledge in our field and the mission of the journal: "Our present knowledge is limited and our working assumption is that by rigorously addressing basic questions we may find truth. It is hoped that these pages will provide a vehicle for the testing of ideas and the emergence of new insights with practical applications."[1] Over the 44 years that have passed since that was written, the fields of infection prevention, healthcare epidemiology, and antimicrobial stewardship (a term not yet coined in 1980) have made significant advancements. Healthcare-associated infection (HAI) measurement has become standard work for hospitals, and national metrics for HAIs now exist. Research and quality improvement activities have expanded to include healthcare settings other than acute care hospitals. Most importantly, hospitals are safer for patients. Much of this progress can be attributed to those who have published their research and observations, raised alarms, and called for action in the pages of ICHE and to those who have read those pages and implemented change in the way in which care is provided, measured, and improved within their own healthcare facilities.

Despite our progress, the words written in 1980 continue to ring true today in terms of our understanding of the role that demographic factors (eg, sex and gender and spoken language), social determinants of health, structural racism, and other socially determined circumstances play in the risk of and outcomes associated with HAIs, antimicrobial resistance, and antimicrobial prescribing practices. Although our knowledge is limited, we know that these factors can and do result in disparate outcomes and inequities in care. For example, recent studies have found higher rates of central line-associated bloodstream infections,[2] hemodialysis-associated *Staphylococcus aureus* bloodstream infections,[3] and hospital-onset methicillin-resistant *S. aureus* (MRSA) bloodstream infections[4] among minoritized racial, ethnic, and language groups, even after adjustment for other known risk factors. We have also seen that, among other factors, socioeconomic and healthcare resource inequities contribute to these disparate outcomes. HAI rates are significantly higher among patients in safety net hospitals as compared to those in non-safety net hospitals.[5] Rates of hemodialysis-associated MRSA bloodstream infections are higher in dialysis facilities located in areas with higher poverty levels.[3] Residents of long-term care facilities with a higher proportion of non-White residents[6] and those located in areas with a higher social vulnerability index or greater neighborhood deprivation[7,8] have carried a disproportionate burden of long-term care facility-associated coronavirus disease 2019 (COVID-19) disease and mortality. Recognizing where, when, and why inequities exist is critical, but it is not enough. We also need to identify strategies to mitigate and ultimately eliminate the contributing factors and then broadly implement those strategies to achieve health equity.

As infection preventionists, healthcare epidemiologists, antimicrobial stewards, researchers, and leaders within our healthcare facilities and beyond, we must use our positions of influence to contribute to the betterment of our healthcare system. We must continue to identify inequities, seek solutions, raise awareness, demand change, and be a part of the change that is needed. I have the privilege of serving as ICHE's editor-in-chief and understand that this privilege comes with responsibility. In this role, I am committed to ensuring that ICHE is a resource for and partner of those committed to safe and equitable health care. In July 2022, ICHE issued a call for papers that address the topics of diversity, equity, and inclusion (DEI) in healthcare epidemiology, infection prevention and control, and antimicrobial stewardship. This call for papers will remain open indefinitely. More than a call for papers, this is also a call for action with the goal of spurring rigorous observation and study so that we can identify, understand, and eliminate disparities in health outcomes, healthcare practices, and opportunities that exist within our own facilities and throughout our healthcare system.

When tackling daunting challenges such as this, getting started is often the hardest part. The invited commentary by Marcelin et al[9] in this month's issue provides a thorough overview of these important topics and, in my opinion, is a must-read for all of us. I also encourage you to visit the DEI Collection on ICHE's website, where all our DEI-related papers are made freely available, to read what others have discovered and what they are doing about the inequities they have found. I hope you will find these resources useful in your own efforts, and I look forward to hearing and reading about what you accomplish.

The mission of the Society for Healthcare Epidemiology of America is safe health care for all. Let's work together to ensure that "all" really does mean all.

Acknowledgments. David P. Calfee is the editor-in-chief of *Infection Control & Hospital Epidemiology*.

Resources

ICHE Call for Diversity, Equity, and Inclusion-Related Papers: https://www.cambridge.org/core/journals/infection-control-and-hospital-epidemiology/announcements/call-for-papers/diversity-equity-and-inclusion

ICHE Diversity, Equity, and Inclusion Collection: https://www.cambridge.org/core/journals/infection-control-and-hospital-epidemiology/collections/diversity-equity-and-inclusion

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