American Journal of Infection Control 53 (2025) 1008–1010

Contents lists available at ScienceDirect

American Journal of Infection Control

journal homepage: www.ajicjournal.org

Brief Report

Opening the door to infection prevention: A survey of a-IPC certificants

Steven J. Schweon RN, MPH, MSN, CIC, LTC-CIP, CPHQ, FSHEA, FAPIC [a,*], Monika Pogorzelska-Maziarz PhD, MPH, CIC, FAPIC, FSHEA, FACE [b], Jessica Dangles MBA, MS [c]

[a] *Infection Prevention Consultant, Saylorsburg, PA*
[b] *Villanova University, M. Louise Fitzpatrick College of Nursing, Villanova, PA*
[c] *No affiliation*

Key Words:
Certification
Associate-Infection Prevention and Control
Entry-level credential

The Associate-Infection Prevention and Control (a-IPC) certification was developed to provide an entry-level credential for infection preventionists and those pursuing careers in IPC. To evaluate its impact, an electronic survey was distributed to 591 a-IPC certificants, yielding 103 respondents (17.4% response rate). The survey explored motivations for obtaining certification, funding sources, perceived benefits, and suggestions for improvement. Survey findings highlight the a-IPC certification value as an entry-level credential for individuals beginning their IPC careers.

BACKGROUND

A certification is a credential awarded by an organization after assessing an individual's skills and knowledge through a formal assessment. The "Association for Professionals in Infection Control and Epidemiology" (APIC) established the "Certification Board of Infection Control and Epidemiology" (CBIC) to be the certifying body and support infection prevention and control certification from novice to expert level.

In 2017, the CBIC Board of Directors (BOD) recognized the "Certification in Infection Control" (CIC) eligibility requirements prevented interested and novice infection preventionist from pursuing certification due to insufficient experience or unmet educational requirements.[1] In response, the BOD developed the "Associate-Infection Prevention and Control" (a-IPC) certification with no eligibility requirements.

The a-IPC certification was intended to measure basic IPC knowledge, serving as an entry-level examination for infection preventionists at the start of their careers. Additionally, the certification provided an opportunity for novice infection preventionists to demonstrate their competency and foundational knowledge in IPC.

Certification was to be obtained by demonstrating competency through a proctored computer-based examination developed by subject matter experts.[2,3] Upon successful completion, the examinee-now known as the certificant-was entitled to use the a-IPC credential.[3] Certificants would be recognized by health care organizations as professionals with a foundational knowledge, interest and dedication to the profession, as demonstrated by passing a standardized, current knowledge measurement.[1,3]

Subject matter experts met to develop the a-IPC certification exam, consisting of 100 items; 85 scored items/15 pre-test/unscored items from the following 8 content domains[2]:

- Identification of infectious diseases processes (14 items)
- Surveillance and epidemiological investigation (15 items)
- Preventing/Controlling the transmission of infectious agents (16 items)
- Employee/Occupational health (7 items)
- Management and communication (7 items)
- Education and research (8 items)
- Environment of care (9 items)
- Cleaning, disinfection, sterilization of medical devices and equipment (9 items)

* Address correspondence to Steven J. Schweon, RN, MPH, MSN, CIC, LTC-CIP, CPHQ, FSHEA, FAPIC, Infection Prevention Consultant.
E-mail address: Sschweon@ptd.net (S. Schweon).

Conflicts of interest: Steven J. Schweon: APIC. APIC Consulting; consultant. Medline; consultant. Safety and Disaster Solutions, Inc; consultant. CBIC; Board of Directors member. APIC Text Online Clinical Editor. SHEA Governmental Affairs Public Policy Committee member. APIC Emerging Infectious Diseases Task Force member. Monika Pogorzelska-Maziarz: no conflicts of interest. Jessica Dangles: I am an APIC employee and Executive Director and paid employee of CBIC-a subsidiary of APIC.

https://doi.org/10.1016/j.ajic.2025.06.007

In May 2020, 6 subject matter experts applied the modified Angoff method, supplemented by the Beuk Relative-Absolute Compromise method, to determine the recommended passing score, which reflects the knowledge required for what a minimally competent entry-level examinee needed to be successful.[2,4]

In 2024, the CBIC Marketing Committee recognized the need for data to demonstrate the certificant's personal and professional impact in acute care, long-term care, public health, and other health care practice settings.

METHODS

To examine the impact of the certification, the CBIC Marketing Committee created an electronic survey consisting of 17 open- and closed-ended questions. Specifically, the survey included 8 closed-ended questions (eg, multiple choice or yes/no) and 9 open-ended questions designed to gather information about motivations for certification, funding sources, renewal intentions, perceived impact on practice, and suggestions for improvement. Demographic items collected included job title, practice setting, years of experience in IPC, and country of residence. Optional questions invited participants to provide contact information and testimonials. Institutional Review Board approval was not required as this survey was conducted for program evaluation and quality improvement purposes. The full list of survey questions is provided in Appendix 1.

The survey was distributed electronically on September 16, 2024, to 591 certificants residing in 10 countries, with a follow-up communication and an October 1, 2024 response deadline. No incentives were provided for participation.

Open-ended responses were reviewed and thematically coded by MPM. Repeating patterns and key concepts were categorized into themes, which were then quantified to identify the most frequently mentioned issues, suggestions, and perceived impacts. Descriptive statistics including means and percentages were used to summarize survey responses.

RESULTS

A total of 103 certificants responded to the survey (17.4% response rate), representing various practice settings, including acute care (49%) and public health (23%). Additional respondents worked in ambulatory care (9%), the health care industry (6%), long-term care (5%), or other settings (9%). Most respondents (60%) had 0 to 5 years of experience in IPC, while 17% had 6 to 10 years, and the remainder had more than 10 years of experience. The majority were based in the United States (78%) or Canada (19%), with 3% residing in other countries.

The primary reasons for obtaining the a-IPC certification were personal satisfaction (67%), employer requirements (20%), and professional development (18%) (Table 1).

Perceived impacts of the a-IPC on personal IPC practice included increased knowledge (33%), credibility (30%), and confidence (16%). A smaller portion reported benefits such as obtaining a new job or better preparation for CIC. However, 15% indicated that the certification had not made a noticeable difference or felt it was too soon to tell.

Nearly half of the respondents (48%) self-funded their certification, while 31% had employer support and 18% received a grant or scholarship. When asked about certification renewal, 53% planned to renew, while 28% were unsure—mostly because they were pursuing a different certification such as CIC or Long-Term Care Certification in Infection Prevention (LTC-CIP) (85%) or were uncertain about remaining in the field (9%). Only 18% did not plan to renew.

When asked about future certification plans, 74% of the respondents had already obtained or were considering CIC or LTC-CIP certification, while 20% were unsure and 6% were not considering it. The top reasons for not pursuing further certification included misalignment with job responsibilities (33%), retirement plans (17%), and barriers such as eligibility issues (17%), financial concerns (17%), and workload or exam difficulty concerns (17%). Respondents highlighted areas for improvement including more targeted study materials (37%), clearer guidance on exam difficulty and purpose (27%), and better understanding of how the a-IPC compares to other IPC certifications (10%). Cost and eligibility concerns were also noted by some participants.

Table 1
Associate-Infection Prevention and Control (a-IPC) certification survey results

	N (%)
Primary reason for taking the a-IPC, n = 103	
Personal satisfaction	69 (67)
Required by employer	21 (20)
Professional development	19 (18)
Increased salary/bonus opportunity	14 (14)
Other	10 (10)
Who paid for the exam? n = 103	
Self-paid	49 (48)
Employer	32 (31)
Employer reimbursed if passed	2 (2)
Grant or scholarship	20 (18%)
Other	1 (1)
Plan on renewing a-IPC certification, n = 103	
Yes	55 (53)
Maybe	29 (28)
No	19 (18)
Reasons for maybe or no, n = 47	
Getting or got CIC or LTC-CIP	40 (85)
Retiring or unsure if will remain in field	4 (9)
Costs	2 (4)
Unclear on what certification entails	1 (2)
Considering pursuing CIC or LTC-CIP certification, n = 103	
Yes (or already have it)	76 (74)
Maybe	21 (20)
No	6 (6)
Reasons for maybe or no, n = 24	
Job role or responsibilities not aligned	8 (33)
Retiring	4 (17)
Eligibility issues (IPC not in job title, LPN)	4 (17)
Financial concerns	4 (17)
Workload or exam difficulty concerns	4 (17)
Anything you wish you had known prior to taking the exam, n = 30	
Overstudied/should have taken the CIC	5 (17)
How the a-IPC relates/compares to the CIC	3 (10)
Additional or more targeted study materials	11 (37)
Clarification on exam difficulty and purpose	8 (27)
Better understanding of exam content or testing process	5 (17)
Difference if any that the a-IPC certification made on your personal IPC practice, n = 80	
Increased knowledge	26 (33)
Increased credibility	24 (30)
Increased confidence	13 (16)
Helped to get a new job in IPC	5 (6)
Professional development	5 (6)
Better prepared for CIC	3 (4)
Other	5 (6)
No difference or too soon to tell	12 (15)
What can be done to improve the a-IPC certification process? n = 61	
Additional or focused study materials or preparation resources	23 (38)
Cost concerns	6 (10)
Eligibility issues	4 (7)
Exam content and question clarity	2 (3)
Logistical issues and timing concerns	2 (3)

CIC, Certification in Infection Control; *LTC-CIP*, Long-Term Care Certification in Infection Prevention.

DISCUSSION

Findings from this survey suggest that the a-IPC certification has value as an entry-level credential for individuals beginning their

careers in IPC. Most respondents reported personal satisfaction, enhanced knowledge, increased confidence, and professional credibility as primary benefits—similar to the positive outcomes reported among LTC-CIP certificants, including improved IPC practices and leadership influence in long-term care settings.[5]

Despite the a-IPC being designed for novices, nearly three-quarters of respondents reported plans to pursue or having already obtained more advanced certifications like CIC or LTC-CIP, suggesting that a-IPC may serve as a stepping stone toward long-term professional development. However, several respondents expressed a desire for more targeted study resources, greater clarity about the exam's scope, and clearer positioning of the a-IPC relative to other credentials. These findings mirror feedback from LTC-CIP certificants[5] who also reported the need for more tailored study materials and content alignment with practice settings.

This survey has several limitations that need to be considered when interpreting the findings. The modest response rate (17.4%) may introduce response bias, as those who perceived greater value from the certification may have been more likely to respond. The certificants self-reporting when assessing the certification impact may be subject to recall bias. The survey design captures a point in time and does not allow for capturing the long-term impact. The study excluded objective performance data such as infection outcome results or job promotion. Nearly all respondents (97%) are from the United States or Canada and may limit the applicability to international health care practice settings. The survey instrument was developed for internal evaluation and has not been formally validated, which may impact reliability.

As certification continues to expand across the IPC career trajectory, understanding how entry-level credentials influence workforce development, role clarity, and organizational recognition will be critical. Broader recognition and institutional support—through funding, mentorship, or integration into onboarding processes—may also enhance the impact of the a-IPC in supporting early-career IPC professionals.

CONCLUSIONS

The a-IPC certification serves as a valuable entry point into IPC, enhancing knowledge, credibility, and confidence among certificants. Further research is needed to assess its long-term impact on career advancement and IPC practice.

Acknowledgments

The authors would like to acknowledge Gail Fraine and Paula St. Hill for their manuscript review. The authors would also like to acknowledge the following CBIC Board of Director Members who facilitated the a-IPC certification development to final release: Karen G. Anderson, Joann Andrews, Dorine Ann Berriel-Cass, Roy Boukidjian, Sandra Calley, Barbara Catt, Robert M. Cooney, Ivan Gowe, Janet Glowicz, Linda Goss, Vincent Hsu, Robert J. Kopchinski, Elaine Larson, James F. Marx, Evelyn McKnight, Frank J. Nemec, Christopher Olson, Terri Rebmann, and Jacie Colyn Volkman.

APPENDIX 1. SURVEY QUESTIONS

The CBIC Marketing Committee created an electronic survey with 17 open and closed-ended questions:

1. What was your primary reason for taking the a-IPC? (select all that apply)
2. Did you, or your employer, pay for the exam?
3. Do you plan on renewing your a-IPC certification?
4. If you answered, "no" or "maybe," to question #3, please explain why:
5. Are you considering pursuing CIC or LTC-CIP certification in the future?
6. If you answered "no" or "maybe" to pursuing your CIC or LTC-CIP certification in the future, please explain your answer:
7. Is there anything you know now that you wish you had known prior to taking the a-IPC?
8. Describe the differences, if any, that the a-IPC certification has made in your personal infection prevention practice (eg, acute care, long-term care, public health, industry, academia, etc)
9. What, if anything, can be done to improve the a-IPC certification process?
10. Please add any additional comments, questions, or thoughts.
11. What is your job title?
12. What is your practice setting?
13. How many years have you been working within infection prevention and control?
14. Where are you currently residing?
15. Please provide your name (Optional)
16. Please provide your e-mail address (Optional)
17. If you would like to provide a testimonial about the a-IPC (anonymous or with your name used), please provide it below:

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