withholding INH preventive therapy from HIV-seronegative recent converters at highest risk for INH-induced hepatitis and death, such as black and Hispanic women over age 35 years and patients with underlying liver disease. The improved live expectancy, as well as societal benefits of INH preventive therapy, argue for the continued use of INH preventive therapy among all other recent TST converters.

FROM: Sterling TR, Brehm WT, Frieden TR. Isoniazid preventive therapy in areas of high isoniazid resistance. *Arch Intern Med* 1995;155:1622-1628.

## Survey Shows Satisfaction With Most JCAHO Services

A national opinion survey conducted for the American Hospital Association (AHA) suggests that hospitals are seeing improved performance by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The poll, conducted by the National Research Corporation of Lincoln, Nebraska, was mailed to 666 hospitals that had been evaluated by the JCAHO from January to May 1995; 49% responded. The survey sought to identify why hospitals seek accreditation by the JCAHO, to assess hospitals' level of support for the accreditation process, and to learn which areas of that process are seen as needing improvement the most.

Using a descending four-point scale to express agreement and disagreement concerning factors related to the accreditor's performance, the respondents gave an overall 3.32 rating to the on-site survey process, a 3.03 rating to accreditation reports, and a 3.02 rating to the presurvey process. Hospital chief executive officers (CEOs) gave a 3.36 rating for their understanding of the impact of the standards on their overall survey score; correlation of the final report with the last-day briefing received a 3.13 rating. Fifty-nine percent of respondents said hospitals should seek accreditation to validate and measure quality and public safety, and another 25% said they seek accreditation to improve quality.

On-site survey teams received generally good marks, with a 3.55 rating for how well they organized the surveys. With respect to the overall value of the commission survey, accomplishing the hospital's goal through the survey received a 3.58 rating, and the relevance of standards to providing quality care received a 3.07 rating.

On a five-point scale, organizational image (4.61) was the leading reason the CEOs cited for seeking accreditation, followed by Medicare certification (4.54), and requirements by third-party payers (4.54).

AHA President Dick Davidson said, "We want to get an objective look at the hospital CEO's opinions about the JCAHO and provide information that the JCAHO could use to improve its efforts. This survey will provide a baseline from which to measure future improvements."

Earlier this year, after several hospitals and state hospital associations complained about the JCAHO's survey process and performance, the organization implemented an action plan for improvement. JCAHO President Dennis O'Leary said that he was pleased that the plan and the commission's Agenda for Change are beginning to show positive results.

FROM: Greene J. JCAHO customers satisfied: poll. *AHA News* September 25, 1995.

## Promoting Adherence to Practice Guidelines

Researchers from Beth Israel Hospital and Harvard Medical School, Boston, Massachusetts, conducted a randomized, controlled, prospective trial of electronic messages designed to enhance adherence to clinical practice guidelines. The study included 126 physicians and nurse practitioners who used electronic medical records when caring for 349 patients with HIV infection in a primary-care practice. Analyses were performed of the response times of clinicians to the situations that triggered alerts and reminders, the number of ambulatory visits, and hospitalizations.

The results indicted that presentation of a set of alerts and reminders as part of computer-based patient record resulted in significantly faster and more complete adoption of practice guidelines by a group of clinicians treating patients with HIV infection. Clinicians acted on alerting conditions (for example, to obtain CD4 counts or to begin prophylactic therapy) in a median time of 11 days if an alert was presented, as compared to 52 days if it was not. In addition, at 1 month after an alert was generated, 29% more of the patients in the intervention group had received appropriate care; at 3 months, the figure was 21%. Clinicians acted on the suggestions of a reminder in a median time of 114 days, as compared with over 500 days if a reminder was not presented.

FROM: Safran C, Rind DM, Davis RB, et al. Guidelines for management of HIV infection with computer-based patient's record. *Lancet* 1995;346:341-346.

## NFID Names CDC's Martone as Executive Director

The National Foundation for Infectious Diseases (NFID) has announced the appointment of William J. Martone, MD, as its new senior executive director. Dr. Martone will be the chief medical officer of the NFID and will have responsibility for the overall direction of the NFID under the guidance of its executive committee. He was detailed to the NFID from the CDC's National Center for Infections Diseases, Hospital Infections Program, for which he serves as director.

A 19-year veteran of the US Public Health Service, Dr. Martone is Clinical Assistant Professor of Medicine at the Emory University School of Medicine and Attending Physician at the Atlanta Veterans Affairs Hospital.

Dr. Martone's appointment completes a transition period that followed the resignation last January of Richard J. Duma, MD, PhD. Commenting on the appointment, Dr. Leon G. Smith, NFID President, stated, "Dr. Martone is in a unique position to serve NFID and CDC in their efforts to control and prevent new and reemerging infectious dis-

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eases." Dr. Martone also is president-elect of the Society for Healthcare Epidemiology of America.

FROM: National Foundation for Infectious Diseases. NFID's new senior executive director. *The Double Helix* 1995;20(3):1.

## National Academy of Sciences Endorses Syringe Exchange Programs

The National Academy of Sciences, a federally chartered independent research organization, recently reviewed research on syringe exchange programs and concluded that these programs should be regarded as an effective component of a comprehensive strategy to prevent infectious disease and that states should rescind laws restricting the sale and possession of syringes. Numerous studies have shown that syringe exchange programs and other interventions that increase access to sterile syringes can prevent infections, including HIV, hepatitis B, and hepatitis C. These findings open the way for the Clinton Administration to lift a legal ban on federal financing of such programs.

Approximately 75 needle exchange programs operate in 55 cities in the United States, using private and other nonfederal financing. Many people fear that such syringe exchange programs would worsen drug abuse and encourage illegal activity. The academy's report said that the HIV epidemic in this country now clearly is driven by infection occurring in the population of injection drug users, their sexual partners, and their offspring. The report also said that the epidemiology of HIV was changing, with the proportion of new AIDS cases represented by gay men down to 47% in 1993 from 74% in 1981, while new cases attributed to the use of illicit intravenous drugs rose to 28% in 1993 from 12% in 1981.

Since the late 1980s, Congress has prohibited the use of federal money to support needle exchange programs. While there are many that support the academy's findings, there also is strong opposition. Dr. Lincoln Moses, chairman of the 15-member panel that prepared the report, said, "the federal government should not force such programs on those that oppose them, but rather remove existing restraints so people can make their own decisions."

Syringe exchange programs are relatively inexpensive, compared with other preventive efforts, because syringes cost less than 10 cents each, and many programs are staffed by volunteers. However, federal prohibitions make it difficult for public health officers to plan and execute compressive AIDS prevention strategies.

FROM: Needle exchanges endorsed as AIDS strategy. *New York Times* September 20, 1995;A:1.

Centers for Disease Control and Prevention. Syringe exchange programs—United States, 1994–1995. *MMWR* 1995;44(37):684-685,691.

## Bloodstream Infections With Needleless Devices

Researchers from the CDC and the Children's Hospital Oakland, conducted a retrospective cohort study of pediatric oncology patients receiving home health care from January 1992 through November 1994. Case patients were those that presented from home with fever, with or without chills, and with more than one positive blood culture.

The only procedural change in these patients was the introduction of a needleless device for central venous catheter (CVC) access in May 1993. The home health agencies provided supplies and limited nursing care, while parents were responsible for maintaining and accessing the central lines at home following training during their child's hospitalization.

Of 185 patients with CVCs during the study period, 59 (32%) contracted 91 bloodstream infections during 75,148 CVC days. All patients with bloodstream infections required hospitalization; none died. Gram-negative organisms were isolated more frequently than gram-positive organisms. Previously reported risk factors, including catheter type, patient age or gender, and diagnosis were not associated with increased bloodstream infection rates. After introduction of the needleless devices into the home healthcare regimen, bloodstream infection rates increased 80% (0.81 versus 1.46 bloodstream infections per 1,000 CVC days).

The data suggest that pediatric patients receiving home health care via needleless devices may be at increased risk for bloodstream infections.

FROM: Kellerman S, Shay D, Howard J, et al. Bloodstream infections associated with needleless devices used for central venous catheter access in children receiving home health care. Presented at the 35th Interscience Conference on Antimicrobial Agents and Chemotherapy, San Francisco, CA, September 17-20, 1995. Abstract J11.

*Additional news items in this issue: Rifampin-Resistant, Isoniazid-Susceptible TB in HIV Patients, page 622.*

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