costs, improved asset utilization, and improved margins. With perceived quality, your products and services have greater value, your market share increases, revenues grow, and profitability is improved.

CONCLUSION

Since 1990, the Baldrige criteria have provided UMH with a structure and road map for change and improvement. Since 1990, four cycles of self-assessment using the Baldrige criteria have enabled the leadership of UMH to identify the areas throughout the hospitals that present the greatest opportunity for improvement. It is our hope the feedback report from the State of Michigan Quality Leadership Award will help us focus our change efforts. From this experience, we are confident that the extension of the Baldrige Award nationally will add value to the healthcare system. We encourage healthcare professionals to embrace and support the Health Care Pilot Program in 1995. It will present new opportunities for knowledge sharing across the healthcare system nationally. Finally, in an area of change and competition, the expansion into health care also will help to establish uniform quality assessment tools across industries and will allow customers in other industries to better understand healthcare quality approaches in the future.

More information about the Baldrige Award, as well as copies of the 1995 Health Care Pilot Criteria, may be obtained by contacting the Malcolm Baldrige National Quality Award, National Institute of Standards and Technology, Route 270 and Quince Orchard Rd., Administration Bldg., Room A537, Gaithersburg, MD 20899-0001; telephone (301) 975-2036, fax (301) 948-3716.

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CDC Implements First Phase of Plan to Address Emerging Infections

by Gina Pugliese, RN, MS
Medical News Editor

The Centers for Disease Control and Prevention (CDC) recently began a national surveillance network in four states to identify new pathogens, resistant organisms, and organisms causing invasive diseases. The four network surveillance sites that have been chosen to begin the emerging infections program (EIP) will be in the state health departments of Sacramento, California; Hartford, Connecticut; Minneapolis, Minnesota; and Portland, Oregon. All the programs will be linked to the university and teaching hospitals in their respective states and will conduct laboratory surveillance for invasive bacterial disease caused by *Haemophilus injluenzae, Neisseria meningitidis,* Groups A and B streptococci, and antibiotic-resistant pneumococci. In addition, all sites will be conducting surveillance for unexplained deaths caused by infections, as well as cases of *Clostridium difficile* to assess its role as a nosocomial and community pathogen.

Certain network sites will be focused on specific infections. For example, Hartford will follow community-acquired pneumonia and analyze risk for *Ehrlichia,* Minneapolis will focus on foodborne illness and cryptosporidiosis, and Portland will collect data on cases of meningitis caused by a rare US strain of streptococcus, Group B type ET5. The network epidemiologists in California will collect data on vancomycin-resistant enterococci at 45 hospitals in San Francisco, including data on the efficacy of laboratory identification and infection control measures.

Grants were awarded to each site from the $6.7 million allocated to implement EIP

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