factors identified by the Lara technology in the first study, including patient body mass index, weight, age, glucose, injection sites, and orientation. Injection access technique and needle gauge were not associated with differences in infiltration rates. Results varied by adherence to the improvement plans. In the 3 centers that completed the phase 2 study ($n = 830$ injections), the infiltration rate decreased by 51% as compared to phase 1 ($n = 815$ injections). In the fourth center, the infiltration rate decreased by >50%. This new technology is quite interesting. Routine incorporation into a busy clinical center for every patient might be challenging, but this technique could be used to train technologists and other professional staff. It also has important implications for clinical trials, for example in qualifying participating clinical trial sites to improve standardization for quantitation.

Maratto et al. from the Hospital of the University of Pennsylvania and Pennsylvania Hospital (both in Philadelphia) reported on "A hands-free solution to potential cross-contamination in nuclear medicine department restrooms" [1627]. Over the course of 20 days, the authors performed wipe tests on commonly touched areas (door handle, light switch, faucet, soap dispenser, floor, flush handle, and toilet seat) in bathrooms in their nuclear medicine and PET departments. They found that in a median of 4 out of 20 days these counts exceeded 200 counts per minute in 1 or more areas. The investigators took these data to their facilities management and then outfitted several of these areas in their bathrooms with hands-free features. They then reperformed the wipe tests and found that contamination decreased in almost all areas. This is important because, although we are all aware that this contamination happens in the nuclear medicine clinic, the introduction of novel agents and therapies may change the extent and nature of the contamination. This type of information is not only a focus of our interest as nuclear medicine professionals, but a focus for regulatory and public discussion. We can use this and similar quality improvement projects to enhance care for patients, document these efforts, and work collaboratively within our institutional systems.

Conclusion

The themes for the General Nuclear Medicine highlights lecture were efficiency, quantitation, development, and outcomes/quality improvement, and I have profiled representative studies presented at the 2018 SNMMI Annual Meeting. Much of the work presented in general nuclear medicine intersected with SNMMI's Value Initiative in Domain 1: Quality of Practice (including abstracts focused on high-quality, value-driven performance and delivery of patient-centered nuclear medicine) and Domain 2: Research and Discovery. The prospective and retrospective studies presented here are laying promising groundwork for future larger, prospective investigations that can positively impact patient care.

NEWSBRIEFS

NIH-Funded Neighborhood Atlas

The National Institutes of Health (NIH) on June 29 issued a press release describing the availability of the Neighborhood Atlas, a new tool to help researchers visualize socioeconomic data at the community level. This online platform allows for easy ranking and mapping of neighborhoods according to socioeconomic disadvantage, including factors such as income, education, employment, and housing quality. The Neighborhood Atlas is based at the University of Wisconsin (Madison) and was described in the June 28 issue of the *New England Journal of Medicine* (2018;378:2456–2458). The project is funded by the National Institute on Aging and the National Institute on Minority Health and Health Disparities (NIMHD), both part of NIH.

"Socioeconomic disadvantage is 1 of the fundamental factors that result in health disparities, and understanding those factors is what will lead to development of interventions to reduce disparities," said Eliseo J. Pérez-Stable, MD, director of NIMHD. "Having a tool to better understand social factors impacting health disparities is an important step forward to achieving health equity." The atlas was developed by Amy Kind, MD, PhD, from the University of Wisconsin School of Medicine and Public Health, and uses the Area Deprivation Index, which includes 17 measures of education, housing quality, and poverty, updated with current American Community Survey data. Users can download maps indexed with measures of neighborhood disadvantage, ranging from national down to local levels.

The Neighborhood Atlas is built so that it can be merged with other data sources to better understand how neighborhood disadvantage affects health. Dr. Kind noted that the Neighborhood Atlas and its data can be harnessed as a new way to advance disparities-focused research, suggesting that it can be used to improve translational, clinical, and community research by showing ways to aid study design, recruitment, retention, and outreach.

The atlas is already being used by the U.S. Centers for Medicare & Medicaid Services to inform local operations and targeting strategies for the *Everyone with Diabetes Counts* program and to predict the increased likelihood of rehospitalization among individuals in disadvantaged neighborhoods. Access to the atlas is available at https://www.neighborhoodatlas.medicine.wisc.edu/.

National Institutes of Health