North Dakota Hospital Association

Innovate·ND

HRET Hospital Improvement Innovation Network

April 27, 2018

Educational Events

HRET HIIN

Measurement Matters: NHSN *Clostridium difficile* Infection (CDI) Surveillance Definition Review
5/03/18 | 1:00-2:00 p.m. CT

HRET HIIN Readmissions Sepsis Fishbowl Series: Part 2
5/08/18 | 11:00 a.m.–12:00 p.m. CT

Culture of Safety Virtual Event - Disaster Preparedness
6/01/18 | 11:00 a.m.-12:00 p.m. CT

HRET HIIN Readmissions Sepsis Fishbowl Series: Part 3
6/12/18 | 11:00 a.m.–12:00 p.m. CT

HRET HIIN Readmissions Sepsis Fishbowl Series: Part 4
7/17/18 | 11:00 a.m.–12:00 p.m. CT

HRET HIIN Readmissions Sepsis Fishbowl Series: Part 5
8/07/18 | 11:00 a.m.–12:00 p.m. CT

Information, registration links and recording links for **all** HRET HIIN upcoming and past virtual events can be found under the "Events" tab on www.hret-hiin.org.

UP Series

Recordings and handouts from Innovate-ND's recent UP series—Wake UP, Script UP, Get UP, and Soap UP – are available here!

Partner Educational Events

Important Dates to Remember

Remember to report your HIIN data in CDS every month!

Deadline	Reporting Period
4/30/2018	Performance data for March 2018 discharges

Quality Milestones Recognition

COPPER Milestone:
Towner County Medical Center – Cando
Kenmare Community Hospital

COPPER, BRONZE & SILVER Milestone:
CHI St. Alexius – Devils Lake
CHI Garrison Community Hospital
CHI Mercy Health – Valley City
Pembina County Medical Center – Cavalier
Sanford Hillsboro Medical Center
CHI St. Alexius Health – Devils Lake

COPPER & BRONZE Milestone:
Ashley Medical Center
Carrington Health Center
CHI Community Memorial Hospital – Turtle Lake
Cooperstown Medical Center
Heart of America Medical Center – Rugby
Jacobson Memorial Hospital – Elgin
Linton Hospital
Mountrail County Medical Center – Stanley
Nelson County Health System – McVille
Southwest Healthcare Services – Bowman
St. Aloisius Medical Center – Harvey
St. Luke's Hospital – Crosby
Tioga Medical Center
Unity Medical Center - Grafton

COPPER, BRONZE, SILVER & GOLD Milestone:
McKenzie County Healthcare System – Watford City
Northwood Deaconess Health Center
Presentation Medical Center – Rolla
Sakakawea Medical Center – Hazen
Sanford Mayville Medical Center
St. Andrew's Health Center – Bottineau
Wishek Community Hospital

COPPER, BRONZE, SILVER, GOLD & PLATINUM Milestone:
Cavalier County Memorial Hospital – Langdon
First Care Health Center – Park River

Sharing YOUR Success: Going for Gold!

Office of Minority Health Resource Center (National Minority Health Month Webinar) | Making the Invisible, Visible: Lessons Learned from a Hispanic/Latino Migrant and Seasonal Farm Worker Needs Assessment
04/30/18 | 11:00 a.m.-12:00 p.m. CT
Register here.

ANA | Emerging Technology and Its Impact on Nursing Practice
05/09/18 | 12:00-1:00 p.m. CT
Register here.

Partnership for Patients PFE Learning Event | The Path for Implementing a PFAC: Step 2. Recruiting and Selecting Advisors
05/10/18 | 12:00-1:00 p.m. CT
Register available soon.

Oral Health America Webinar Series

Oral Hygiene: Caring for the Older Adult with Dementia
05/03/18 | 2:00-3:00 p.m. CT
Register here.

Self-Reported Oral Health Data vs. Oral Screening Data: What's the Story?
05/17/18 | 2:00-3:00 p.m. CT
Register here.

PFCC Partners | Core Competencies of Effective Partners Training for Patient Family Advisors
05/11/18 & 05/18/18 | 4:00–5:00 p.m. CT
Register here.

National Coordinating Center
Integrating Alcohol and Depression Screenings into Whole-Person Care
05/19/18 | 2:00–3:30 PM CT
Register here.

APIC 2018
45th Annual Conference
06/13/18-06/15/18 | Minneapolis, MN
Registration is open!

Great Plains QIN
Improving Care Coordination by Working with Super-Utilizer Patients
06/27/18 | 12:00–1:00 p.m. CT
Register here.

Nine Innovate-ND|HRET HIIN hospitals participated in the April 18 CAH Quality Network Meeting opportunity to share a success story about work that they are doing to improve care in their facilities. The presentations were divided into two themes: Community Engagement—sharing work that has extended beyond the walls of the hospital to the entire care continuum, or in some cases to the extended community; and Patient and Family Engagement—sharing their work in utilizing patient feedback to improve care and/or developing Patient and Family Advisory Committees.

Sharing a success story is a criterion for the Innovate-ND Gold milestone, and for many, it was the final criterion they needed to reach this status. Two hospitals, **Cavalier County Memorial Hospital in Langdon, and First Care Health Center in Park River**, had completed all of the criteria for the Platinum milestone but had not yet shared a success story so they catapulted from Silver to Platinum with that task completed. A copy of the PowerPoint slides for all nine hospitals is available on the Innovate-ND webpage, by clicking on the Presentations tab.

Thank you to all the speakers for preparing and presenting your work. Learning from each other is what a "network" is all about!

Community Engagement:

- Bridging Health and Home Program: Doris Vigen, DON, and Melissa Mostad, Clinical Care Leader, Sanford Medical Center-Mayville
  - Improved confidence in chronic disease self-management ultimately reducing readmissions, as well as reduced Hgb A1C and better managed hypertension, resulted from efforts around medication reconciliation involving a pharmacist, utilization of the Better Choices, Better Health® chronic disease management program and a Transitional Care Nurse Visit.
- System-Wide Antibiotic Stewardship Program: Coleen Bomber, Department Manager of Clinical Support Services, Northwood Deaconess Health Center
  - Described efforts to implement system-wide the Core Elements in the CDC's Antibiotic Stewardship Programs, to improve antibiotic usage and decrease antibiotic resistance and to develop a facility antibiogram.
- Hospital Discharges—Striving for Patient Success: Molly Nelson, Nursing Care Coordinator, Sakakawea Medical Center in Hazen (See article in Readmissions Section of this newsletter).
  - Development of a medical neighborhood approach to empower patients to achieve their wellness potential by changing the focus from the disease process to the whole person.
- Tools in improve HCAHPs Scores and Care Coordination: Wade Burgess, Central QI Coordinator, Presentation Medical Center in Rolla
  - Summarized interventions including hourly rounding, pharmacy assistance with discharge teaching, post discharge calls, assuring furniture in the patient rooms allowed for optimal communication with patients, implementing post discharge follow-up calls, updating new employee orientation, inclusion of all staff in implementing new policies and procedures, and

SAVE THE DATE

Quality Health Associates of North Dakota 2018 Quality Forum
08/23/18 | Bismarck, ND

NATIONAL PATIENT SAFETY FOUNDATION WEBCASTS

The National Patient Safety Foundation (NPSF) now offers complimentary access to past NPSF webcasts. Check back often to see what is available. Visit the NPSF Webcast Archive website and follow the instructions on your screen.

RESOURCES

LISTSERV®
Sign up and help meet our goal of approximately 1,000 subscribers per LISTSERV® topic. These platforms enable peer-sharing and are used to promote virtual events and highlight innovative topic-specific strategies to

articles in monthly hospital newsletter that have led to improved HCAHPs scores.

Patient and Family Engagement

- Patient and Family Engagement Strategies: Megan Thompson, Patient Care Coordinator/PFAC Coordinator, and Alexa Holt, Clinical Coordinator
  - Shared multiple approaches to involve patients and families in their care to improve quality, safety and patient satisfaction including bedside reporting, hourly rounding, patient information boards, room orientation guides, use of walkie-talkies, use of Omnicell to reduce medication errors, and development of a Patient and Family Advisory Committee.
- Improving Discharge Planning: Lisa LeTexier, Co-CEO, and Arvadell Sharp, DON, Pembina County Medical Center, Cavalier, ND
  - Outlined their journey to a 39% reduction in Readmissions through interventions including care boards in patient rooms, follow-up calls post ER visits, improvement in discharge instructions, sharing of HIIN progress reports, staff education, improved documentation of patient needs and referrals, and bedside reporting.
- Root Cause Analysis on Falls: Aaron Johnson, VP of Patient Care, and Melissa Hodous, UR Coordinator and Educator, CHI Devils Lake Hospital
  - Reviewed the process to analyze a serious safety event resulting in improved safety processes, implementation of bedside reporting, improved communication, and reduction of noises that stimulate patients.
- Readmission Reduction—Teach Back and Follow-up Calls: Jenifer Lauckner, Assistant Nurse Manager, St. Andrew's Health Center, Bottineau, ND
  - Recognized the need to improve patient education and discharge planning resulting in standardizing discharge planning processes using Ask Me 3® Assessment, Teach Back, and Discharge follow-up calls.
- Development of a PFAC: Lindsey Mehlhoff, DON, and Jessica Tank, Quality Assurance Coordinator, Cavalier County Memorial Hospital, Langdon, ND
  - A walk through the steps of involving the patient and family at all levels of care from the bedside to the boardroom.

April 28 is "World Day For Safety And Health At Work 2018"
Click here to find resources for this and other national awareness days!

FEATURED RESOURCES

Hospital Elder Life Program Mobility Change Package and Toolkit
To support your hospital's work in moving away from a focus on restricting mobility for safety to a focus on providing safe mobility to promote health and healing, a new tool kit is available. *Hospital Elder Life Program Mobility Change Package and Toolkit* provides a

reduce harm. New subscribers are added on the first day of each week.

On the Web
The HRET HIIN website is a one-stop-shop for all HRET HIIN information and events! Check it out at www.hret-hiin.org.

Social Media
Follow the HRET HIIN on Twitter @HRETtweets! Here they'll be promoting virtual events, highlighting recruitment numbers, state partners and hospitals! Re-tweet, reply or like their posts and share your HIIN journey using #WhyImHIIN.

You can also join the HRET-HIIN on Facebook and LinkedIn. Follow the instructions for joining by clicking on the correlating icon on the right-hand side of the page when you log onto the HRET HIIN website (www.hret-hiin.org)

INNOVATE-ND SUPPORT TEAM

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conceptual framework, roadmap, and step-by-step interventions designed to guide a team in implementing a Mobility Program. The resource includes a comprehensive bibliography, tools, resources, and helpful hints from sites that have implemented mobility programs. This toolkit has now been adapted and published for public use and is available in the HRET HIIN Resource Library and can be accessed here.

Read more about this toolkit in the Falls section of this newsletter.

ADVERSE DRUG EVENTS

Healthcare Provider Drug Diversion/Substitution Addressed
NY One & Only Campaign Workgroup member Kimberly New, JD, BSN, RN, recently presented on healthcare provider drug diversion/substitution and the patient safety harm it poses, at a recent national conference of the Society for Healthcare Epidemiology of America (SHEA).

As you know, healthcare diversion/substitution is a prime concern of the national and NY One & Only Campaigns. So we are sharing a link from the coverage of the event by "Contagionlive" hoping you and your facility might benefit from New's expertise.

Click here to read more.

ANTIBIOTIC STEWARDSHIP

COMING SOON: CDC to Launch Module 2 of Antibiotic Use Training Course (+ Free CE) in Summer 2018
The CDC has launched the first module of our online antibiotic stewardship course and are gearing up to release the second module in early summer. To date, they have more than 10,000 registered users! We encourage you to take the course, share your feedback with us, and share this opportunity (including the attached flyer) with your partners and colleagues! Course objectives include optimizing antibiotic prescribing and use to protect patients and combat the threat of antibiotic resistance; informing healthcare professionals about proper antibiotic use, and encouraging open discussion among doctors and patients.

Course breakdown:

- Section 1 (Antibiotic Resistance and Threats/Benefits of Antibiotic Stewardship) – *available now*
- Section 2 (Antibiotic Stewardship in Outpatient Settings/Communication Practices)
- Section 3, part 1 (Urinary Tract Infections/Skin and Soft Tissue Infections)
- Section 3, part 2 (Bronchitis/Sinusitis)
- Section 3 part 3 (Acute Otitis Media/Pharyngitis)
- Section 3 part 4 (Dentistry)
- Section 4 (Emergency Department/Inpatient/Long-Term Care)

Doctors, nurse practitioners, physician assistants, certified health education specialists, nurses, pharmacists, and public health

practitioners with a master's degree in public health are eligible to receive up to eight hours of free CE for the entire course.

Additional sections of the course will be released throughout the year. To register and take the course online, create an account at http://bit.ly/2BsVc0z.

New CDC Resources

- *Be Antibiotics Aware* materials for Consumers and Providers in SPANISH! These can be ordered here.
- Association for Professionals in Infection Control and Epidemiology (APIC), the Society for Healthcare Epidemiology of America (SHEA), and the Society of Infectious Disease Pharmacists (SIDP) Joint Position Paper on Antibiotic Stewardship. Check it out here: here.

What's the CDC Doing to Fight Superbugs?

Find out how new resistance data will be used The PEW Charitable Trusts.

Louisiana Hospitals Implement Successful Sepsis Transfer Process

Maryanne Whitney, Cynosure Improvement Advisor | 4/19/2018 HRET HIIN Sepsis Listserv post

When hours and minutes make the differences in diagnosing and treating septic patients, sepsis can be a life-threatening condition. Unfortunately, critical access hospitals (CAHs) are not equipped to manage sepsis care, and must transfer septic patients to larger acute care facilities.

In an effort to support effective transfers, the Health Education and Research Trust (HRET) Hospital Improvement Innovation Network (HIIN) and Cynosure Health launched the national Sepsis Safety Network for Accelerated Performance (Sepsis SNAP)–an innovative project consisting of CAH and acute care hospital pairs across eight states.

Ochsner Medical Center and St. James Parish Hospital from the Louisiana Hospital Association Research and Education Foundation emerged as Sepsis SNAP Program champions. They implemented successful transfer protocols and have plans to spread efforts to 15 hospitals. Key activities and accomplishments included:

- Formalizing collaborative relationships between hospitals and their EMS partners;
- Creating a system-level transfer call center that initiates communications, ensures the proper processes are started, and decides which campus will accept the transferred patient; and
- Spreading their innovative sepsis transfer processes to five partner hospitals, with plans to expand to fifteen soon!

Please see the Sepsis SNAP section of the of the HRET HIIN website to learn more.

Hospital-Acquired Infections

CDI Surveillance Definition Review Event

Join the HRET HIIN on May 3 from 1:00 p.m.-2:00 p.m. CT for the Measurement Matters: NHSN *Clostridium difficile* Infection (CDI) Surveillance Definition Review event. We invite you to register and email us your questions on the January 2018 update in the CDC Multidrug-Resistant Organism & *Clostridium difficile* Infection (MDRO/CDI) Module.

Falls

Movement Towards Movement

by Jackie Conrad, Cynosure Improvement Advisor | April 23, 2018
HRET HIIN Rural CAH Listserv®

There is a "Movement towards Movement" in the HRET-HIIN as organizations recognize the value of developing and resourcing progressive mobility programs. The *Hospital Elder Life Program Mobility Change Package and Toolkit* is an outcome of the work by Dr. Sharon Inouye. This resource was developed for a Mobility Action Group consisting of 100 participating hospitals working to improve mobility and decrease the use of bed and chair alarms in hospitalized seniors. This toolkit has now been adapted and published for public use and is available in the HRET HIIN Resource Library and can be accessed here.

The toolkit includes a conceptual framework, roadmap and step-by-step guide for setting up a mobility program and includes the following useful resources:

- Mobility protocols
- Competency checklists for "lay" or volunteer mobility assistants
- Mobility assessment tools
- Mental status screen
- Mobility documentation tools
- Visual reminders and signage for recording ambulation
- Patient and family educational materials
- Mobility aide job description
- 9 Hospital case studies
- Plus, the HRET HIIN Falls STOP to START Improving Falls Injuries document is included in this toolkit!

The toolkit aligns well to support the three "Must Haves" for HRET HIIN Get UP:

- **Walk in, walk during, walk out**: perform mobility assessment on admission and progress mobility to pre-admission status.
- **Grab and go mobility devices**: have gait belts and other mobility devices readily available to nurses, mobility aides and patients
- **Three laps a day keeps the nursing home at bay:** document patient mobility and aim for three episodes outside the room per day.

For additional tools and resources, check out the HRET HIIN Falls Change Package and additional resources at http://www.hret-hiin.org/topics/injuries-from-falls-immobility.shtml.

READMISSIONS

Hospital Discharges: Striving for Patient Success

Facility:
Sakakawea Medical Center (Critical Access Hospital)
Coal Country Community Health Center-FQHC (Hazen, Beulah, Center, Killdeer)

Project Team Members:
Molly Nelson, RN, Nursing Care Coordinator (SMC)
Marcie Schulz, RN, Director of Patient Care (SMC)
Amy LaVallie, LSW (SMC)
Alyssa Kelsch, PharmD (SMC)
Chastity Dolbec, RN, Director Patient Care and Innovation (CCCHC)
CCCHC Chronic Care Coordinators
Visiting Nurse Services
Jen Wolff, RN, Community Care Coordinator
Knife River Care Center-Beulah, ND

Anticipation, confusion, fear, anxiety—these are feelings many patients experience on the day of their discharge. Brand new information regarding a disease process, new medications and follow-up appointments can be overwhelming to them. Sakakawea Medical Center (SMC), in collaboration with Coal Country Community Health Center (CCCHC), recognized these feelings and a saw an opportunity for improvement and change. In an effort to help patients succeed after discharge, SMC created a nursing care coordinator position. The nursing care coordinator is tasked with preparing patients for discharge by reviewing their plan of care, answering questions and addressing any educational needs that may arise in preparation for discharge. The nursing care coordinator also provides primary care with a warm handoff once the patient is discharged and conducts patient follow-up calls that include inquisition on discharge instructions, medication regimen, in-home services, ability to obtain new prescriptions, reminders on upcoming appointments and overall patient satisfaction. The nursing care coordinator's goal is to inspire patients to take ownership of their health through education and empowerment.

By designating a nurse to oversee patient education, our patients receive more thorough, one-on-one instruction and have an opportunity to ask questions and express concerns. During patient visits, the nursing care coordinator inquires with patients about their current knowledge of their disease state, explains the patient's plan of care and provides any pertinent patient education. By utilizing teach-back methods, the nursing care coordinator can accurately assess the patient's understanding of the presented patient education.

Patient visits also allow the nursing care coordinator to assess the patient's understanding of the Advance Care Planning process. If desired, the nursing care coordinator can assist the patient plan for future healthcare choices. This process can also be completed on an outpatient basis, with the patient and nursing care coordinator meeting one-on-one at the hospital.

SMC conducts a discharge planning meeting daily. In attendance are SMC's licensed social worker, nursing care coordinator, pharmacist, nursing staff, physical, occupational and respiratory therapists and dietary director. This meeting gives each discipline an opportunity to share insight on the patient's progress and discharge plan. Daily discharge planning also allows staff the opportunity to identify needed referrals such as Visiting Nurse Services, hospice, community care coordination, diabetic education through CCCHC and Meals on Wheels.

The community care coordinator provides Chronic Care Management Services to patients. If a patient has Medicare and lives with two or more chronic conditions, the patient can be referred to Chronic Care Management Services. This service supports patients staying in their homes, safely, for as long as possible by setting up services such as housekeeping, assistance with bathing and assisting the patient in obtaining adaptive equipment. The community care coordinator is a patient advocate who helps patients “connect the dots” by working closely with all entities involved in the patient’s healthcare.

Visiting Nurse Services are provided through CCCHC for ours and surrounding communities to patients who are homebound. The program is similar to Home Health Services; however, only skilled nursing is provided to the patient. All therapy services are provided by SMC through outpatient therapy. This is an example of the collaborative effort put forth by CCCHC and SMC to provide our patients with services that extend beyond the walls of the hospital or clinics. The nursing care coordinator oversees patient discharges, ensuring each patient is sent home with an accurate medication list as well as scheduled follow-up appointments and referrals. The nursing care coordinator works hand-in-hand with the hospital pharmacist to provide patients accurate medication lists as well as education on their medication regimen.

SMC, CCCHC and Knife River Care Center (KRCC), our skilled nursing facility in Beulah, work collaboratively to continuously review and improve our process for warm handoffs. By providing a warm handoff to the patient’s primary care provider, we truly create a healthcare neighborhood for our patients. Upon discharge, pertinent patient information, including a transitional care worksheet, is sent from SMC to the chronic care coordinators working with the patient’s primary care provider in the clinic setting. The transitional care worksheet includes the LACE index scoring tool as well as a level of risk designation for our Medicare population. The transitional care worksheet also includes hospital course, medication changes, upcoming appointments and referrals made. This information is used by the chronic care coordinator to conduct pre-visit planning for the patient’s Transitional Care Management visit (for Medicare beneficiaries) or follow-up visit. If the patient is a resident of KRCC, their hospitalization information is sent to KRCC as well as the chronic care coordinator working with the patient’s primary care provider.

Confident, empowered and prepared—these are the feelings we are working to cultivate in our patients. The nursing care coordinator at SMC works closely with the chronic care coordinators at CCCHC as well as our community care coordinator to collaboratively ensure our patients are not forgotten once they are discharged from the hospital and to prevent readmissions in our medical neighborhood.

PFE

Community

Skills Exchange

Engagement

PFCCpartners proudly supports the Patient Family Advisory Network. The **PFAnetwork** consists of patients & families who are currently serving in the Advisory role in hospitals, healthcare organizations, research, and improvement organizations. We are committed to developing a community of Advisors who are prepared, who have access to resources and the support they need to become fully engaged partners for co design of improvement in healthcare systems, program development and policy to support patient family centered care.

Visit the **PFAnetwork** website and to sign up to receive more information on Community events, Skills Exchange, Engagement Opportunities: https://pfanetwork.org/

How to Engage Patients and Families to Address Opioid Misuse

Patients and families are essential partners in the effort to fight the opioid misuse epidemic. As you work towards implementing the PFE metrics, here are some specific ways to utilize and engage patients and family members and incorporate their perspective:

- **PFE Metric 1: Preadmission Planning Checklist**
  - *Introduce* the concept of pain management and opioid use, especially around surgery where pain is a part of the hospital stay and recovery process
  - *Create* a partnership with patients and families around pain management to prevent addiction to opioids and to manage their pain successfully
- **PFE Metric 2: Shift Changes Huddles or Bedside Reporting**
  - *Discuss* pain management goals and how to manage pain during and after the hospital stay, including the use of alternatives to opioids
- **PFE Metric 4: Patient and Family Advisory Council or Patient Representatives on Hospital Committee**
  - *Incorporate* the patient and family perspective on opioid use by encouraging previous patients or family members to share their story or experience in your meetings or committees
  - *Create* patient- and family-centered collaborations with hospital representatives
- **PFE Metric 5: Patient Representative on Board of Directors**
  - *Capture* and use the patient and family perspective to inform broad policy about opioid use and pain management in the hospital, and initiate community partnerships to address opioids in the community

The links below offer some resources that HIINs and hospitals can use to help get patients and families involved in addressing this significant public health problem.

- Patient engagement is critical to treat chronic pain, opioid use disorder
- Engaging Patients to Optimize Medication Adherence
- Safe Transitions of Care for Patients on Opioids
- Management of patients with issues related to opioid safety, efficacy and/or misuse: a case series from an integrated, interdisciplinary clinic
- An Action Guide for Management of Opioid Dependence: Next Steps for Patients and Families
- Patient Perspective on Opioid Addiction: A discussion guide for you and your patient
- PfP Strategic Vision Roadmap for PFE: Metric 1 Digest

WORKER SAFETY

The Joint Commission Sentinel Event Alert: Physical and Verbal Violence Against Healthcare Workers

The Joint Commission released a [Sentinel Event Alert] (SEA) on April 17, 2018 in regards to violence directed at healthcare workers. According to the Occupational Safety and Health Administration (OSHA), approximately 75 percent of nearly 25,000 workplace assaults reported annually occurred in health care and social service settings and workers in health care settings are four times more likely to be victimized than workers in private industry. The focus of this alert is to help your organization recognize and acknowledge workplace violence directed against health care workers from patients and visitors, better prepare staff to handle violence, and more effectively address the aftermath. The Joint Commission would like state hospital associations to highlight the SEA in their communications and distribute it to hospitals as needed. Additionally, The Joint Commission has created an infographic related to the SEA that is also available for distribution. Click the infographic to view a larger version.

Disparities

Health Disparities Articles and Resources

Following are recent publications and resources you may find valuable in your work to eliminate health disparities in the healthcare your hospital and healthcare system.

- CMS Office of Minority Health | Racial, Ethnic, and Gender Disparities in Health Care in Medicare Advantage
- Health Affairs | Medicare Program Associated With Narrowing Hospital Readmission Disparities Between Black And White Patients (Abstract)
- Health Affairs | Integrating Data On Social Determinants Of Health Into Electronic Health Records (Abstract)

Miscellaneous

May 6-12 National Hospital Week

National Hospital Week celebrates hospitals, health systems, and the women and men who support the health and well-being of their communities through dedication and care from the heart. Celebrating National Hospital Week provides an opportunity to thank all of the dedicated individuals – physicians, nurses, therapists, engineers, food service workers, volunteers, administrators and so many more – for their contributions. See the AHA's NHW website for more information and resources on the week.