North Dakota Hospital Association Innovate-ND

HRET Hospital Improvement Innovation Network

March 6, 2020

Educational Events

HRET HIIN

PI Collaborative Sessions
03/09/20 | 12:00-1:00 p.m. CT
Register here.

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.

Event Recordings

All HRET HIIN event recordings are/will be available on-demand on the HRET HIIN website http://www.hret-hiin.org/. Select the desired topic and scroll down to "Watch a Recent Data Event."

Partner Educational Events

AHA Value Initiative | Telehealth: Taking Care to the Next Level
03/10/20 | 1:00-2:00 p.m. CT
Register here.

Sepsis Management and Performance Improvements
03/10/20 | 1:00-2:00 p.m. CT
Register here.

AHA Physicians Alliance | The Business Case for Humanity in Healthcare
03/17/20 | 12:00-1:00 p.m. CT
Register here.

Important Dates to Remember

Remember to report your HIIN data in CDS every month!

Deadline	Reporting Period
03/23/20	Performance Data for February 2020 Discharges *(Please note the earlier date for February Discharges, as this is the last month of data submission before the end of the HRET HIIN contract.)* Several hospitals have shared concerns that they would like to maintain data collection and submission in an effort to ensure a complete set of data, and recognize its value in monitoring and sustaining improvement. Following March 31, CDS will close. Plans are in process to ensure that there is a mechanism to submit data going forward. We will keep you informed as the plans unfold.

Shout Outs!

North Dakota has been recognized in making significant improvements during the HIIN in PFE and has been asked to highlight our work in HRET's final report to CMS. Congratulations on this overarching achievement that impacts so many challenging measures! We are anxious to receive the results of the final PFE/HEOA report that was just closed on February 22.

Thank you to the 15 Innovate-ND hospitals who have met 100% of the PFE Metrics per the 12/19 survey:

- Ashley Medical Center
- CHI Mercy Health, Valley City
- CHI St Alexius – Community Memorial Hospital, Turtle Lake
- CHI St. Alexius Health – Dickinson Medical Center
- CHI St. Alexius – Garrison Memorial Hospital
- Carrington Health Center
- Cavalier County Memorial Hospital & Clinics, Langdon
- First Care Health Center, Park River
- Jacobson Memorial Hospital Care Center, Elgin
- Pembina County Memorial Hospital, Cavalier
- Sakakawea Medical Center, Hazen
- Sanford Hillsboro Medical Center
- St. Andrew's Health Center, Bottineau
- Unity Medical Center, Grafton
- Wishek Community Hospital and Clinics

POLST Conversations and Implementation ZOOM Events
Register for one of 14 monthly events to be held beginning 03/18/20 through 09/09/20.
Register here.

Blood Pressure Protocol Training
03/19/20 | 10:30-11:30 a.m. CT
Holiday Inn | Fargo, ND
Register here.
Limited to the first 25 registrants!

5th Annual Hypertension Summit
03/19/20 | 12:30-5:30 p.m. CT
Holiday Inn | Fargo, ND
Register here.

SAVE THE DATE!
Center for Rural Health North Dakota Critical Access Hospital Board Boot Camp
04/17/20 | 8:00 a.m.-5:00 p.m. CT
More information coming soon!

Alzheimer's Association – ND Chapter
If you, your staff, your residents or their families ARE STRUGGLING WITH THE IMPACTS OF DEMENTIA, PLEASE CHECK OUT CARE CONSULTATION, provided FREE ONLY in North Dakota by funding through the ND Department of Human Services, Aging Services Division.

How does ND compare to the nation and the HRET HIIN? We rock!

Source	PFE 1*	PFE 2	PFE 3	PFE 4	PFE 5
National (n=3,958)	70%	86%	74%	61%	55%
HRET HIIN (n=1,566)	79%	89%	76%	58%	53%
North Dakota (n=31)	67%	77%	77%	61%	71%

**Percentages for PFE 1 do not include exempt hospitals, 399 are exempt from National, 216 from AHA HIIN, and 22 from this AA.*

QUALITY MILESTONES RECOGNITION

COPPER Milestone:

COPPER, BRONZE & SILVER Milestone:
Cooperstown Medical Center
Heart of America Medical Center – Rugby
Southwest Healthcare Services – Bowman
St. Luke's Hospital – Crosby

COPPER & BRONZE Milestone:
Ashley Medical Center
Kenmare Community Hospital
Mountrail County Medical Center – Stanley
Nelson County Health System – McVille
St. Luke's Hospital – Crosby
Tioga Medical Center
Towner County Medical Center – Cando

COPPER, BRONZE, SILVER & GOLD Milestone:
CHI Community Memorial Hospital – Turtle Lake
CHI Mercy Health – Valley City
Linton Hospital
Northwood Deaconess Health Center

COPPER, BRONZE, SILVER, GOLD & PLATINUM Milestone:
Carrington Health Center
Cavalier County Memorial Hospital and Clinics – Langdon
CHI Garrison Community Hospital
CHI St. Alexius – Devils Lake
First Care Health Center – Park River
Jacobson Memorial Hospital – Elgin
McKenzie County Healthcare System – Watford City
Pembina County Memorial Hospital – Cavalier
Presentation Medical Center – Rolla
Sakakawea Medical Center – Hazen
Sanford Mayville Medical Center
Sanford Hillsboro Medical Center
St. Aloisius Medical Center – Harvey
St. Andrew's Health Center – Bottineau
Unity Medical Center – Grafton
Wishek Community Hospital

TAKEheart Recruitment

Every year, over one million Americans qualify for cardiac rehabilitation (CR); however, only 20% of them participate. The AHA Center for Health Innovation is recruiting hospitals and healthcare systems for a new initiative to increase utilization of cardiac rehabilitation (CR). Hospitals and healthcare systems are invited to join the TAKEheart Learning Community now at no cost to exchange information with a network of peers about broad evidence-based strategies to increase CR referral, enrollment and retention! Click here to learn more about the free

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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 reduce harm. New subscribers are added on the first day of each week.
Send your questions on your work with hospital-acquired conditions through the LISTSERV.

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.

resources offered by TAKEheart or to join the TAKEheart Learning Community.

The initiative aligns with AHRQ's EvidenceNOW project, which has helped promote evidence-based strategies in cardiac care among more than 1,500 small- and medium-sized primary care practices. AHRQ also offers a variety of resources on topics such as blood pressure and cholesterol control and smoking cessation to help people prevent heart disease or manage an existing condition. Read more.

FEATURED RESOURCES

NDC3 – Creating a Healthier North Dakota

NDC3 is helping communities across North Dakota create a culture of health, where prevention and wellness are the norm. NDC3 programs give you the tools you need to take control of your own health and manage in a way that works best for you and your life. NDC3 programs provide education, fitness instruction, and self-care strategies for participants; they do not replace clinical care provided by doctors, nurses and other medical professionals. The evidence-based programs help people across the state experience improved wellness and quality of life.

What are "evidence-based" programs?
Evidence-based programs are developed and verified by researchers to promote self-management of chronic health conditions (such as diabetes and chronic pain), prevent falls, and foster individual well-being. NDC3 offers evidence-based programs for:

- Preventing Falls
- Preventing and Managing Diabetes
- Managing Chronic Conditions and Pain
- Powerful Tools for Caregivers

Learn more about NDC3 Programs, or Find a Class near you.

PEER SHARING

Benefits of Bedside Shift Report

Hospital Wide Listserv | Feb 13-14, 2020

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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Q: We are about to implement shift report at bedside. Would any of you who practice this be willing to share your procedure? We are already receiving some nurse push back citing worries about maintaining HIPAA, and other real or perceived barriers. Any information, the negatives and positives, is greatly appreciated. ~P. Howell, RN, George Regional Hospital, Lucedale, MS.

A: We do a modified version of this. While the charge nurses are counting narcotics, the other nurses off going and on coming go and do a quick bedside "handoff"—essentially "Good morning Mr. Smith, I am rounding with Tayler who will be taking care of you for her shift. Is there anything you need right now?" They look at any IV sites together that are in use and make sure the patients are clean, dry, etc. If the patient is sleeping, they quietly go into the room and check these things. Most of the patients are awake at shift change in the morning because of VS being taken, weights, and labs so it's not an issue. At the 7 p.m. shift change, they are usually all awake and nurses will do the same handoff. They then do a report which is usually completed in 10-15 minutes. My staff gave a lot of push back with actual report at bedside, and I work shifts also and see the concerns. Sometimes patients do not understand all of our medical jargon and it can cause some anxiety with them so we find this modified version better fitting for our staff and patients. Our patients have given us feedback that they really like the handoff because they feel more updated on who is taking care of them next and when they will be back in to check on them. I hope this helps! ~A. Johnston, RN, ACNO, Beaver County Memorial Hospital

A. I'm a bit biased because I think bedside shift report is appropriate and beneficial for staff as well as patients/families. Since we should be seeing our patients as part of the team, it only makes sense for them to hear report. Occasionally, there is a unique situation where we may have to save a topic for back at the nursing station, but I really think it is rarely necessary. We found patients and families have much to add. One example was when the day shift nurse told the night shift nurse about a procedure that was done. The patient spoke up and said that actually that had never occurred. Troubleshooting ensued. We found that this process allowed us to uncover errors and near misses (IV tubing clamped so med not administered, wrong rate on the IV pump, IV site issues, dressing problems, etc.). Accountability improvement reduced the "1st shift didn't do this" and "night shift never does that" back and forth. When they go to see the patient together, things are addressed in a straight forward, collegial manner. Hope this is helpful for you! ~D. Campbell, RN-BC, MSN, CPHQ; KY HIIN

A. You may want to take a look at these Nurse Bedside Shift Report resources from AHRQ: an implementation handbook, training slide set and more. On a personal note, I worked closely with a unit to implement bedside shift report a number of years ago. We offered space for nurses to have their concerns addressed, offered a list of resources for them to review regarding the benefits of engaging patients/families in bedside reporting, and provided opportunities for them to practice scenarios where they were asked to share information about a patient/family member that felt uncomfortable to address (e.g., HIV status, socioeconomic risk factors, etc.). ~T. Bristol Rouse, MA, CPHQ, CPXP, BCPA; AHA

A. We experienced all of the same. It is a powerful tool for both staff and patients when used appropriately and consistently! ~D. Baird, RN; Gila Regional Medical Center, Silver City, NM

A. I am attaching some resources that I found helpful when we implemented bedside report and hourly rounding. I'm sure we had many of the same barriers you have, especially the concerns about patient privacy. The first document discusses HIPAA and incidental disclosures; if you scroll to the Frequently Asked Questions, the issue of talking to patients in a semi-private room is addressed. The key message we focused on was "yes, this will feel uncomfortable at first, but it is the best thing for our patients AND most patients want to be involved in their care." We had a great example of the benefit of bedside report the very first week we implemented. The off-going nurse commented that there was a concern about the patient's BP running on the higher side and that they had been watching this closely. The patient said "well, you know, I haven't had my BP meds since I had surgery." The nurses determined that these meds had been missed with post-op med rec; they were restarted and all was well. This really helped sell the idea to our nursing staff! ~S. Michl, RN, CPHQ; Filmore County Hospital, Geneva, NE

ADEs

Association of Default EMR Settings with Health Care Professional Patterns of Opioid Prescribing in the ED

Montoy JCC, Coralic Z, Herring AA. JAMA Intern Med. 2020.

Prescription opioids play a significant role in the ongoing opioid crisis. This study examined whether reducing the default settings in the electronic health record (EHR) for number of opioid tablets for prescriptions could lower the number of pills actually prescribed by 104 health care professionals at two large, urban emergency departments. Results suggest that this easy to implement, low-cost intervention could be helpful in combatting the opioid epidemic. Read more.

Antibiotic Stewardship

How Facilities Can Combat Resistance

Pew - The Rundown

Quote of Note: "The bottom line is the [antibiotic] stewardship is effective. To me, it's a no-brainer." ~Shannon Phillips, MD, chief patient experience officer at Intermountain Healthcare

Read more.

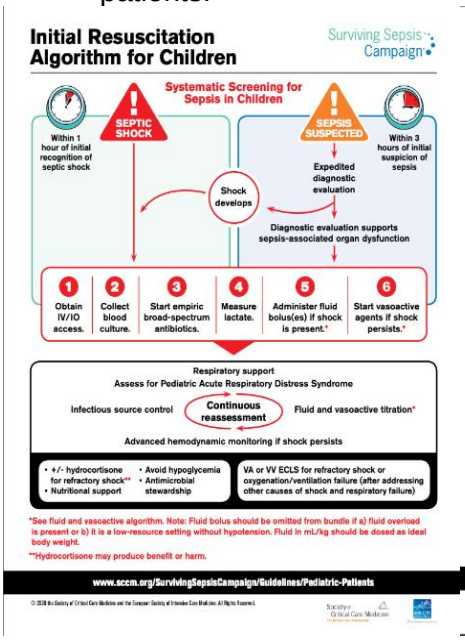
Sepsis

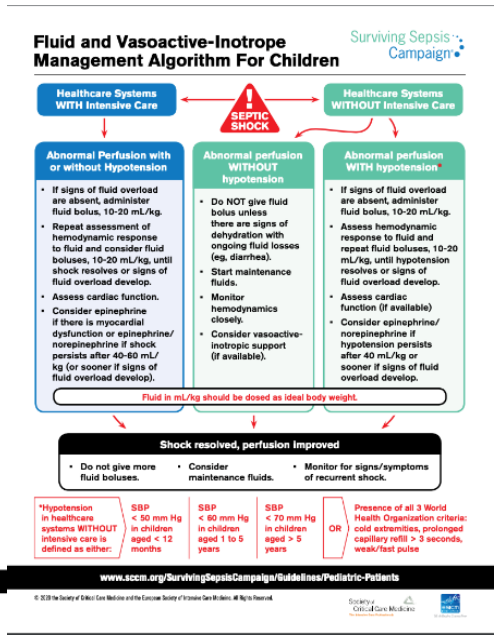
New Tools for Sepsis

The SCCM Surviving Sepsis Campaign continues to enhance tools to assist in the reduction of sepsis mortality. Here are some of the most recent:

1. Early Identification of Sepsis on the Hospital Floors: Insights for Implementation of the Hour-1 Bundle
   - This guide focuses on sepsis recognition in the inpatient setting and how to coordinate resources. It also discusses the most common barriers and strategies to overcome them.
2. The first release of guidelines for sepsis in children by SCCM SSC during the 2/2020 Congress

- https://www.sccm.org/SurvivingSepsisCampaign/Guidelines/Pediatric-Patients
- An infographic tool for those practitioners caring for pediatric patients.





HAIs

CMS Focusing Inspections on Infection Control

CMS is suspending non-emergency inspections of healthcare facilities to concentrate on preventing the spread of Novel Coronavirus 2019 (COVID-19). Specifically, CMS announced that, effective immediately and, until further notice, State Survey Agencies and Accrediting Organizations will focus their facility inspections exclusively on issues related to infection control and other serious health and safety threats. CMS also prepared guidance documents for infection control and prevention in hospitals and nursing homes. Read these memos from the CMS Center for Clinical Standards and Quality/Quality, Safety & Oversight Group:

- Ref: QSO-20-12-All: Suspension of Survey Activities
- Ref: QSO-20-13-Hospitals: Guidance for Infection Control and Prevention Concerning Coronavirus Disease (COVID-19): FAQs and Considerations for Patient Triage, Placement and Hospital Discharge
- Ref: QSO-20-14-NH: Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes

What Plumes are Lurking in your Hospital?

Barb DeBaun | HRET-HIIN Infections Listserv

Toilet plume. Plume, you say? Sounds like such a nice word (i.e., ‘a long, soft feather’) but let’s put this in context. When a toilet is flushed, an aerosolized cloud of microscopic particles (including urine and feces) spray into the air and onto surrounding surfaces. Toilet plume is why most people don’t store their toothbrushes in an open container near the toilet. It may not make you sick, but it is kind of gross when you think about it.

So what role do bioaerosols generated from toilet flushing in rooms of patients with C. difficile infection play? A recent paper by Wilson, et al., https://doi.org/10.1017/ice.2020.11 concluded that bioaerosols produced by toilet flushing may contribute to the contamination of the environment. Their sample size was not large enough to detect a true difference in contamination before and after flushing. However, they did detect an increase in bioaerosols after flushing compared to baseline, so it appears that the act of flushing has an impact on how much plume is generated.

We all know that most clinical settings do not have a toilet seat cover. And even if they did, covers are not fool proof as there is still a gap between the cover and the seat.

Questions:
1. Have you addressed this and if so, how?
2. Are you doing anything special/different when cleaning bathrooms in the rooms of known CDI patients?

(And Nikki wants to know…where is the patient's toothbrush?)

PRESSURE ULCERS

Pressure Ulcer Prevention for the Obese Patient Population

Bariatric Safe Patient Handling and Mobility Guidebook: A Resource Guide for People of Size addresses equipment needs, care planning and safe patient handling strategies. Having the right equipment in place before the patient is admitted to a floor or unit is key. Processes should be activated as soon as the patient is known to registration or arrives in the emergency room to assure timely activation of bariatric beds, surfaces, chairs and wedges.

FALLS

Patient Activation Related to Fall Prevention: A Multisite Study

Jt Comm J Qual Patient Saf. 2020

The Fall TIPS (Tailoring Interventions for Patient Safety) program has been shown to be effective in preventing inpatient falls through formal risk assessment and tailored patient care plans. This study demonstrated that patients with access to the Fall TIPS program are more engaged and feel more confident in their ability to prevent falls than those who were not exposed to the program. Read more.

READMISSIONS

Effects of Nurse Home Visits in Post-Discharge Heart Failure Patients

Kim Werkmeister | HRET HIIN Hospital-wide Listserv

A recent study and subsequent editorial in the Annals of Internal Medicine concluded that nurse home visits (NHVs) after hospitalization for heart failure increased quality-adjusted life-years, increased survival, and decreased the number of rehospitalizations in the patient's lifetime. While the study was relatively small, the implications for providing enhanced services after discharge for certain high-risk populations are promising.

Providing enhanced services such as nurse home visits for high-risk patient populations may reduce readmission rates, and more importantly, improve quality of life for those patients.

Implementation of a Discharge Education Program to Improve Transitions of Care for Patients at High Risk of Medication Errors

Ann Pharmacother, 2019

Pharmacists play an important role in patient safety, particularly bridging transitions of care between inpatient and outpatient settings. This study assessed the impact of a discharge medication education program for high-risk patients, including scheduling a post-hospital discharge telephone follow-up within two days of discharge. This intervention increased the number of patients who were successfully contacted post-discharge (from 20% pre-intervention to 78%) and seen in clinic within 14 days (from 49% to 60%) and reduced the 30-day readmission rate (from 19% to 10%).

VTE

Updated VTE Recommendations for Patients with Cancer

Kim Werkmeister | HRET HIIN Hospital-wide Listserv

Patients with a cancer diagnosis are at risk for the development of venous thromboembolism (VTE). The American Society of Clinical Oncology (ASCO) recently released updated recommendations about prophylaxis and treatment of VTE in patients with cancer following a meta-analyses of randomized controlled trials published between 2014 and 2018.

Changes to previous recommendations include:

- Clinicians may offer thromboprophylaxis with apixaban, rivaroxaban, or LMWH to selected high-risk outpatients with cancer
- Rivaroxaban and edoxaban have been added as options for VTE treatment
- Patients with brain metastases are now addressed in the VTE treatment section
- The recommendation regarding long-term postoperative LMWH has been expanded

ASCO also reaffirmed the following current recommendations:

- Most hospitalized patients with cancer and an acute medical condition require thromboprophylaxis throughout hospitalization.
- Thromboprophylaxis is not routinely recommended for all outpatients with cancer.
- Patients undergoing major cancer surgery should receive prophylaxis starting before surgery and continuing for at least 7 to 10 days.
- Patients with cancer should be periodically assessed for VTE risk, and oncology professionals should provide patient education about the signs and symptoms of VTE.

PFE

Ready to Start a PFAC?

About 60% of Innovate-ND | HRET HIIN participating hospitals have already developed a PFAC, but if your hospital isn't one of them, a new toolkit is available to make this work less daunting. The Colorado Hospital Association provides tools, resources, timelines, and more in a step-by-step plan. Find the Patient Family Advisory Council 2019 Toolkit here.

Some of the many benefits hospitals have recognized include:

- Improved quality and patient safety
- Improved financial performance
- Improved HCAHPS® Hospital Survey scores
- Improved patient outcomes
- Enhanced market share and competitiveness
- Increased employee satisfaction and retention
- Response to The Joint Commission standards

Social Determinants of Health

Spirituality: An Overlooked Social Determinant of Health

by Nikki Medalen, MS, BSN

My neighbor called. Her mother is dying of cancer and has delirium interspersed with periods of lucidity that seem to be associated with how well her pain is controlled. She tells me that as her mother enters another cycle of delirium, she just prays the sorrowful mysteries of the rosary over and over, and I am gripped by a deep appreciation for how spirituality and/or religion penetrate and influence every moment of life…and death and are often enhanced during our most emotional experiences.

The World Health Organization defines social determinants of health (SHD) as "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life….[which include]…economic policies and systems, development agendas, social norms, social policies and political systems" (WHO, 2015). But is this definition complete? In her book *Religion as a Social Determinant of Health*, Ellen Idler (2014) describes how individual religious behavior, faith communities and religious institutions can be principal instigators of health interventions as well as promoters and mediators of individual health practices and beliefs. For some, it is expressed through habitual individual practice and embodied by social institutions. She goes on to state, "religion is present in most societies both downstream and upstream and should be considered alongside its social, political, and economic counterparts if we are to have a complete framework of the social determinants of health" (Idler, 2014).

Social determinants of health are more than just buzzwords or a fad in healthcare. No approach to healthcare would be complete without addressing factors such as food security, adequate housing, transportation, insurance coverage, gender identity, military service and other impacts on a person's continuum of wellness. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), wellness "concerns maintaining an overall quality of life and the pursuit of optimal emotional, mental, and physical health." It is not just the absence of disease, it is the "presence of purpose in life, active involvement in satisfying work and play, joyful relationships, a healthy body and living environment, and happiness" (SAMHSA).

A person's daily practices or behaviors are influenced by their spiritual beliefs, which intersect at many points with wellness, including exercise, clothing and diet. A fascinating example can be found in Victor Fuchs book, *A Tale of Two States*, where he compares all-cause, all-age mortality rates between Nevada and Utah in 1974. He found stunning differences despite their relatively similar populations and climate, such as a 69% higher mortality rate among Nevadan women, and a 45% increased risk for infant mortality compared to Utah. Smoking and alcohol-related deaths were also much higher in Nevada. Fuchs determined that Utah generally had healthier lifestyles because of daily life habits that promoted healthy living which were informed, in part by their Mormonism, which prohibits smoking and alcohol consumption, while encouraging social practices like marriage and childbearing. In a follow-up study forty years later, results remained consistent.

So how do we begin to weigh the impact any individual's spiritual or religious beliefs impact their wellness, illness, treatment or recovery? Two clinical tools are available, and interestingly neither are new. FICA and HOPE allow the healthcare provider to non-judgmentally assess and develop a plan of care with the patient that incorporates their beliefs.

F – Faith and Belief (i.e., do you consider yourself spiritual or religious?)
I – Importance (i.e., does your spirituality influence you in your healthcare decision making?)
C – Community (i.e., are you involved with a faith community?)
A – Address in Care (i.e., how would you like me to address your faith and health?)
Find more information at The GW Institute for Spirituality and Health.

H – Spiritual Resources (i.e., where do you find sources of hope during difficult times?)
O – Organized Religion (i.e., Are you a member of an organized religion? Are there any religious practices that you find you personally important?)
P – Personal Spirituality (i.e., What spiritual practices are most helpful to you?)
E – Effects on care (i.e., Do you hold any beliefs that might interact with the care I might give? Do you wish to consult with a religious or spiritual leader when you are ill or making decisions about your healthcare?)
Find more information at CT Faith Community Nurses (requires registration).

Some suggestions are offered by the George Washington Institute for Spirituality and Health:

1. Consider spirituality as a potentially important component of every patient's physical well-being and mental health.
2. Address spirituality at each complete physical examination and continue addressing it at follow-up visits, if appropriate. In patient care, spirituality is an ongoing matter.
3. Respect a patient's privacy regarding spiritual beliefs; don't impose your beliefs on others.
4. Make referrals to chaplains, spiritual directors, or community resources as appropriate.
5. Be aware that your own spiritual beliefs may help you personally and could overflow in your encounters for those for whom you care to make the provider-patient encounter a more humanistic one.

And one of my own…regardless of your differences, always maintain unconditional positive regard for your patient.

MISCELLANEOUS

AHA Podcast: A Conversation About the Future of Healthcare Innovation

In this podcast, Jay Bhatt, DO, AHA Senior Vice President and Chief Medical Officer, and Andy Shin, Chief Operating Officer of the AHA Center for Health Innovation, discuss major trends for 2020 and beyond as healthcare organizations build teams to advance clinical care and drive innovation. Click here to listen!

Encouraging Health Behavior Change: New Strategies and Partnership

A new AHA issue brief and case studies share proven interventions, strategies and examples to promote healthy behaviors and improve individual and community health. Using data to set and track priorities, screening for positive and risky health behaviors, and engaging strategic partners in the community, hospitals can play a pivotal role to foster positive behaviors, improve health and well-being, and achieve health equity. Click here to learn more.

CDC Publishes Interim Estimates of 2019–20 Seasonal Influenza Vaccine Effectiveness

CDC published Interim Estimates of 2019–20 Seasonal Influenza Vaccine Effectiveness—United States, February 2020, in the February 21 issue of MMWR (pages 177–182). A summary for the press is reprinted below.

CDC's interim flu vaccine effectiveness (VE) estimates show that the flu vaccine has reduced doctor visits associated with flu illness by almost half (VE = 45%) so far this season. This is consistent with estimates of flu vaccine effectiveness from previous seasons that ranged from 40%–60% when flu vaccine viruses were similar to circulating flu viruses. Vaccination is providing substantial protection (VE = 55%) for children, who have been particularly hard hit by flu this season.

Up-to-Date Coronavirus Information from CDC and WHO

CDC and WHO are closely monitoring an outbreak of respiratory illness caused by a novel coronavirus (COVID-19), first identified in Wuhan, Hubei Province, China. Be sure to check these sources for continual updates.

The ABCs of CBD | MedlinePlus

CBD, or cannabidiol, is a chemical in the Cannabis sativa plant, also known as marijuana or hemp. You may have heard about treating a variety of medical conditions using CBD. But what does science say? Learn more about an FDA approved medication and CBD-focused research in the NIH MedlinePlus Magazine.