

Planning for an Influenza Pandemic in the Home Health Care Sector

Wednesday, September 23rd, 2009
1:00-2:30 pm EDT

On the top of the slide are the logos for the Department of Health & Human Services and the Agency for Healthcare Research and Quality (AHRQ).

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Questions

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Agenda

- Introduction, Kelly Johnson and Geraldine Coyle
- National Perspective Home Health Care Pandemic Preparedness, Barbara Citarella
- New York State's Efforts to Prepare for H1N1 in the Home Care Sector, Alexis Silver

- Veterans Health Administration Home Based Primary Care Planning for an Influenza Pandemic, Geraldine Coyle
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- Use of Home Health Patient Risk Assessment Tools for Emergency Planning, Andrea Hassol

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Home Health Care Resources

- *Mass Casualty Events Models and Tools To Support Planning and Response for Pandemic and All Hazards Preparedness*
 - Under development
- *Home Health Care During an Influenza Pandemic: Issues and Resources*
 - <http://www.pandemicflu.gov/plan/healthcare/homehealth.html>

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Considerations from: *Home Health Care During an Influenza Pandemic*

- Need for community collaboration and business continuity
- Understanding the community planning process
- Addressing workforce issues
- Changes in parameters of patient care
- Legal and ethical concerns

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National Perspective Home Health Care Pandemic Preparedness

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Initial Findings of First Wave 2009

- Preparation for pandemic was evident
- Not prepared enough
- Health care system was overwhelmed
- Communications did not go well
- School closings were a major problem

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Initial Findings for Home Health

- Staffing problems
- Triage of patients/altered standards of care
- Ran out of Personal Protective Equipment (PPE)
- Unclear where to get additional supplies
- Unsure how much to order
- Surge capacity

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AHRQ 2008 Report

- Compare the 2009 first wave with *Home Health Care During an Influenza Pandemic: Issues and Resources*, which was released in July 2008
- What do we find?

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2008 Report Conclusions

- Home health would be an essential component of a national response
- Actively engaged in community planning
- Surge will strain home health industry

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Right on the Money

- Community involvement is not on a consistent basis
- Cannot have a national response plan without all health care providers involved
- Not every home health provider has access to their State's Health Alert Network (HAN)
- The home health industry does not know the emergency response language

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On the Money

- Many home health providers did not know the difference between universal and standard precautions
- Child care was an issue
- Unclear who the community partners were and are
- Did not know where to go to get information related to their practice

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What Role Can Home Health Expect To Play?

- A bigger role as we prepare and are entering wave 2
- Key player related to surge capacity
- Key player related to response and containment
- Will not be able to stop the spread, but we can mitigate the effects

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What is home health doing around the country?

- National Incident Management Systems (NIMS), National Response Framework (NRF), and Incident Command System (ICS) education
- Tabletop exercises
- Workshops to determine surge capacity
- Workshops to determine PPE needs for 6-8 weeks
- Some State associations have a seat at the Emergency Operations Center (EOC)
- Grant monies for education, PPE practice, fit testing, co-op planning
- Home health part of triage teams

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What To Do Now

- Communicate with the local office of emergency managers
- Get additional supplies
- Educate staff
- Stay informed and have a personal plan

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Remember

- *Chance favors the prepared mind*
- Louis Pasteur, 1822-1895

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Poll Question #1

- A short poll will appear on your screen. Please take a few seconds to answer the poll and provide valuable feedback!

- If you are unable to respond to the poll during this event, please e-mail your answer to emergencypreparedness@academyhealth.org.

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New York State's Efforts to Prepare for H1N1 in the Home Care Sector

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New York Experience

- Terrorist attacks
- Weather
 - Ice, snow, floods, hurricanes
- H1N1- large outbreak in April 2009
- Power outages, transit strikes

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New York Environment

- Home care required to have disaster plans (2005)
- Mandatory flu shots for most health care workers
- Most likely – mandatory H1N1 vaccinations
- Planning for H1N1 based on solid all- hazards planning

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Background & Infrastructure

- Small grant from New York State Department of Health (NYSDOH)
- Provider collaboration/workgroups
- Working from top down
- Working from down up
- Home care is still misunderstood – role not clearly defined
- Many respectful disagreements along the way

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Agency Preparedness Survey Summer 2009

- This graph represents survey results from NY home care providers and shows two “peaks of readiness” for pandemic flu, surge capacity, and flood or hurricane.
- Overall, providers felt almost as ready for Pandemic Influenza as they did for floods and hurricanes. They were much less confident in the area of surge capacity.
- Biggest gap in planning: staff, especially paraprofessional, planning for self and family.

The slide shows a graph in the center of the screen that represents survey results from New York State home care providers. The graph has the number of responses on the y-axis and the score, from 0-10, on the x-axis. Responses were gathered on pandemic flu, surge capacity, and flood/hurricane and the data shows two “peaks of readiness” for pandemic flu, surge capacity, and flood or hurricane.

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Concerns

- Staffing, Personal Protective Equipment (PPE), Conflicting responsibilities, and guidance
- Plans x 3
 - Agency
 - Staff & Families
 - Patients & Families
- Community Partners
- Keeping Patients out of the Emergency Department (ED) and hospital
 - Patient education
 - Staff education
 - 911 screening
 - Ensuring ability to provide IV hydration at home

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Solutions: Education in General

- Annual conference
 - Best practices
 - Tabletop
- Regional meetings
- Webinars – Pandemic “web - top” & conference calls
- 2007 – Homeland Security Exercise and Evaluation Program (HSEEP) Compliant Equine Flu Tabletop
- Modules on Web site, www.homecareprepare.org
- Home health aid trainings, <http://www.ncdp.mailman.columbia.edu/h1n1v2/podcasts.html>
- Handbook (now obsolete)
- Web site postings & links

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Solutions: Education H1N1

First Wave

- Memos
- Resources
- Web site
- Participation with NYSDOH on conference calls with providers
- Serving as Point of Contact (POC) for provider issues

Second Wave

- All first wave plus...
- Vaccine information
- Collaboration with health system as a whole in surge planning

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Solutions: Tools

- Hazard vulnerability assessment
- Incident Command System (ICS) cross walk
- Abbreviated assessment tool
- Surge tool kit
- Electronic phone book
- Patient planning materials
- Staff education materials
- Sheltering planning materials
- Ethics discussion – altered standards of care
- NY ventilator allocation plan education

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Going Forward

- Working with NYSDOH on establishing “triggers” for specific actions to expand surge
- Facilitating State-provider bi-directional communication:
 - Epidemiology
 - Surveillance
 - Trends
 - New guidances
- Working with providers on risk reduction
- Continuing to assist with staff and patient education materials
- Continue to work within larger emergency management arena
- Advocate for legislation to support cost of home care preparedness

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**Veterans Health Administration (VHA)
Home Based Primary Care (HBPC)
Planning for an Influenza Pandemic**

Geraldine A. Coyle RN, EdD, CNAA
Deputy Chief Consultant
Emergency Management Strategic Healthcare Group
Veterans Administration

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VHA Health Care System

- The Department of Veterans' Affairs has:
 - 159 medical centers
 - Over 800 clinics
- Home Based Primary Care (HBPC) Departments:
 - Located in 134 medical centers
 - Vary in both size and structure
 - Provide comprehensive long term care to veterans with complex chronic disabling diseases

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Experiences During the Spring 2009 Outbreak

- Due to the huge geographic area covered by VHA, the experiences varied.
- In communities where the outbreak was nonexistent in the HBPC population, staff had time to be trained by Infection Control.

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Experiences (cont.)

- In communities affected by the H1N1 virus, staff:
 - Developed policies for contact and respiratory isolation
 - Developed Frequently Asked Questions (FAQ) fact sheets
 - Provided education to veterans and their families
- Viral laboratory testing was performed as needed

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Lessons Learned from the 2009 H1N1 Outbreak

- Some programs faced the reality that they did not have plans in place to cover staff who might have to stay home with school children or ill family members
 - Staffing plans became a concern
- Denver HBPC developed a plan to place “Influenza Kits” in veterans homes. Contents included:

- Digital thermometer
- Alcohol gel
- Masks
- Patient education on treatment of symptoms

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Lessons Learned (cont.)

- Some HBPC programs were located in medical centers where:
 - Employees and family members would be covered with antivirals
 - Only employees would be covered with antivirals
- Recent events have led Home Care leaders to recognize the need for a Family Plan to cover contingencies with dependents and pets

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Surge Capacity

- VA Medical Centers, like community counterparts, have little spare bed capacity
- In some communities, VA staff scramble, looking for community nursing home beds daily
- Some HBPC programs are in the early stages of integrating planning with community home care agencies for care in the community

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Staffing Concerns for Surge Capacity

- Some HBPC programs believe their staff may be pulled to provide care to acutely ill patients
- Some HBPC programs are designing staffing plans where 1 or 2 staff provide routine care and the remainder of the staff prioritize emergency care to the HBPC population
- Other programs plan to provide care on an as needed basis

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Staffing Concerns for Surge Capacity (cont.)

- Plans are underway to save time by not going into the office:
 - Nursing staff will drive from their own home to the veterans home
 - This also supports the “social distancing” concept
- Monitoring of care will be spread across the department by involving medical center respiratory care staff to contact the respiratory services vendor in the community

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Conclusion

- Progress has been made in preparing for the return of the H1N1 pandemic influenza virus
- Further actions need to occur to fully prepare staff, veterans, and their families to be ready to meet this challenge

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Poll Question #2

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Pandemic Influenza Preparedness Hits Home: Home-based usability testing for pandemic response materials

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Program Background

- The CDC pandemic preparedness communication team developed a “how to” booklet, titled “What you can do to fight the flu,” to provide people with information they need to take care of household members with flu.

The slide shows the cover of the “What you can do to fight the flu” booklet developed by the Centers for Disease Control and Prevention. The booklet is about 20 pages and is written in both English and Spanish.

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Findings

- The Home Care Guide is currently being revised based on the feedback from both in-home and facility testing
- The booklet, when it is completed, will be available:
 - On-line
 - In both English and Spanish
- It is expected to be completed by November.
- Specific findings of the testing will be made available at that time as well

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Testing Design

- Two types of testing
 - Cognitive interviews (CIs)
 - In-home Usability Testing
- Population interviewed
 - Low socioeconomic status (SES)
 - High school education
 - Caucasian
 - African American
 - Hispanic

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Testing Design

- Premise: Serve as a single information source for home care in a severe pandemic
- Went into people’s homes and asked them to perform the behaviors contained within the booklet

- In-home usability testing provided the most accurate way to determine whether or not people could actually perform the specific recommended behaviors in the booklet

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Methodology

- Interviews
 - 5 English; 4 Spanish
 - 7 women; 2 men interviewed
 - Internal Review Board (IRB) approved
 - Informed consent
 - Duration approximately 2 hours
 - Incentive provided (\$100.00)
 - Semi-structured interviewer guide
 - Videotaped usability testing if participant agreed and signed an image release form

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The Home Care Booklet

- Participants were given 15 to 20 minutes to review the booklet
- Interviewers then asked questions about:
 - Understanding the meaning of recommendations
 - Likelihood of following recommendations
- Participants were then asked to gather the necessary ingredients to make:
 - Salt water gargle
 - Electrolyte drink
 - Sick room

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Findings

- Sick room
 - People said that they had most of the elements to make the room but when asked to supply them they did not have all the items they thought they had
 - When asked to go through the motions of making a sickroom, people had questions about the use of various items (i.e., paper towels, trashcan liners)
 - People did not understand the need for a humidifier to put moisture in the air
 - The CIs revealed that people would not make a sickroom. The in-home interviews showed that they would try to make a sick room particularly if they had multiple children.

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Findings (cont.)

- Rehydration drink
 - Although no problems were identified in the cognitive testing, people did not have all the ingredients or measuring spoons and cups
 - They did not know how to improvise these measures or convert from teaspoons to tablespoons or the reverse
 - One mother worried that she might harm her child if she made the solution incorrectly
- Saltwater Gargle
 - Similar challenges were found as were seen in the rehydration drink
 - Lack of ingredients
 - Lack of measuring devices
 - Concern for making the mixture in the correct way

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Summary

- This project demonstrates the importance of incorporating realism into the testing of health communications materials.
- This may be one of the first attempts to conduct home-based usability testing of any pandemic influenza communication material.

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Summary (cont.)

- In home usability testing has an enormous potential to provide a “real world” assessment of health communication and education materials in that they provide the closest approximation of situations in which they would be used.
- This testing strategy provided extraordinarily rich usability data on actual health communication materials and could potentially serve as a model for the evaluation of other public health communication materials.

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Use of Home Health Patient Risk Assessment Tools for Emergency Planning

Andrea Hassol, Abt Associates (Project Director)

Project Contributors: Donna Hurd, Abt Associates; Richard Zane MD, Brigham and Women's Hospital (P.I.); Paul Biddinger MD, Massachusetts General Hospital (P.I.)

Acknowledgements: Deborah Deitz, Abt Associates (HH specialist), Expert Advisory Panel, Kelly Johnson (AHRQ), Sally Phillips (ASPR)

*Funded by the Agency for Healthcare Research and Quality and
the Health Resources and Services Administration*

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Study Purpose

Problem Statement:

- Emergency Planners need to know how many home health (HH) patients are likely to require emergency department (ED) or hospital admission during emergencies/disasters.

Study Purpose:

- Identify common elements in patient risk assessment tools used by home health agencies (HHAs)
- Determine utility of these tools for emergency planning & response
- Suggest standardized "model" tool

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HH Patients at Highest Risk of ED/Hospital Admission During Emergencies

- Bedbound without a caregiver; unable to get food or fluids; immobilized or paralyzed
- Ventilator dependent
- Oxygen dependent
- IV infusion
- Using high tech equipment (e.g., wound vac, pleurovac)
- Dependent on a skilled service (e.g., respiratory therapy) that if not delivered puts the patient at extreme risk
- Receiving injectable medication and unable or not yet trained on the procedure
- Dialysis patients (more than 3 times weekly)
- Severe dementia or Alzheimer's disease

- Severely mentally disturbed or retarded
- Daily wound care

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Study Design

- Literature review
- Expert Panel Meeting
- Interviews with 21 HHAs in six States regarding their tools for patient risk assessment
- Interviews with 4 other community service providers regarding patient risk assessment

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Patient Risk Assessment Tools: Preliminary Findings

- Every HHA has its own tool – no standardization
 - Example: Level I usually highest risk, sometimes lowest risk
- Larger HHAs use electronic risk assessment tools; smaller HHAs use paper or none at all
- Few HHA risk assessment tools specifically address emergency/disaster scenarios
- No published research evaluating utility of different various tools, especially for disaster planning

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Patient Risk Assessment Tools: Preliminary Findings

- Considerable Variability

16 Rating Tools Reviewed:

2-level system Based on Timeframe only (1)

e.g. must be seen within 24 hrs, 48 hrs

3-level system Based on Timeframe (3)

Based on Care Needs/Diagnoses (6)

Combination of Care & Support Needs (3)

Combination of Care Needs and Timeframe (1)

4- level system Combination of Care Needs and Timeframe (1)

5- level system Combination of Care Needs, Support, and Response to Disaster (1)

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Utility for Emergency Planning: Preliminary Findings

- Most HHAs have too many patients in the highest risk level (20-25%) to visit during an emergency

- Clinicians prioritize ad hoc during emergencies
- Availability of caregivers may change during emergencies, shifting a patient to higher risk level
- Clinicians who know patients best may be unavailable for ad hoc triage during an emergency
- Few HHAs share identity/address of highest risk patients with local emergency responders (e.g. fire)

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Preliminary Recommendations

- Standardize risk levels as low/medium/high rather than inconsistent numeric ratings
- Use common, available data to improve consistency across patients and HHAs
- Rating Tool should address:
 - Care needs/diagnoses
 - Informal supports/caregivers (which if missing would change patient risk level)
 - Timeframe for visits
- Automated systems should have capability to print or transmit lists of Level I patients (with addresses) for emergency responders

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Preliminary Recommendation: Care Needs and Diagnoses

- Specify risk in several subcategories to aid prioritization:
 - Clinical conditions and most problematic diagnosis
 - Activities of daily living (ADL) dependency
 - Medication management
 - Medical procedures and treatments
 - Management of equipment
 - Supervision and safety

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Preliminary Recommendation: Caregiver Availability

- Draw data from OASIS-C (2010) to assign risk levels:
 - **Low risk:** No assistance needed, or caregiver provides assistance
 - **Medium risk:** Caregiver available, but needs training/support, or caregiver capability unclear
 - **High risk:** Assistance required, but caregiver unavailable or unable to assist

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Preliminary Recommendation: Risk Levels and Timing

- **High Risk/High Priority:** Patient requires uninterrupted services and is highly unstable; deterioration or inpatient admission is probable if the patient is not seen for regularly scheduled visits.
- **Medium Risk/Medium Priority:** Regularly scheduled visits may be delayed somewhat with telephone contact.
- **Low Risk/Low Priority:** Patient medical condition is stable; patient can safely miss scheduled visit(s) with basic care provided by self or caregiver.

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Suggested “Model” System

This slide shows a chart that contains three rows: Clinical Condition, ADL dependency, and medication management. The chart also contains three columns: low risk (in green) means that no assistance is needed or a caregiver can safely provide assistance; medium risk (in yellow) means that a caregiver might be available but would need training to assist the patient; high risk (in red) means that no caregiver is available, or a caregiver could not safely provide the necessary assistance. Each cell in the chart explains the OASIS-C data elements that would be used to characterize a patient by risk level. For example, the ‘low risk’ for management of equipment would be OASIS-C code M2100e score of 0 or 1; ‘medium risk’ for management of equipment would be OASIS-C code M2100e score of 2 or 4; ‘high risk’ for management of equipment would be OASIS-C code M2100e score of 3 or 5. When an individual patient’s scores are arrayed, the color coding would quickly identify the high risk (red) patients, and which of their needs contribute to this elevated risk.

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Suggested “Model” System (cont.)

This slide shows a chart that contains four rows: medical procedures and treatments, management of equipment, supervision and safety, and other factors. The chart also contains three columns: low risk (in green) means that no assistance is needed or a caregiver can safely provide assistance; medium risk (in yellow) means that a caregiver might be available but would need training to assist the patient; high risk (in red) means that no caregiver is available, or a caregiver could not safely provide the necessary assistance. Each cell in the chart explains the OASIS-C data elements that would be used to characterize a patient by risk level. For example, the ‘low risk’ for management of equipment would be OASIS-C code M2100e score of 0 or 1; ‘medium risk’ for management of equipment would be OASIS-C code M2100e score of 2 or 4; ‘high risk’ for management of equipment would be OASIS-C code M2100e score of 3 or 5. When an individual patient’s scores are arrayed, the color coding would quickly identify the high risk (red) patients, and which of their needs contribute to this elevated risk.

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Closing Remarks

- Home Care Industry Perspective
- New York State Perspective
- VA Health System Perspective
- CDC's Community Education Perspective
- Research and Development Perspective

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For more information about...

- *Home Health Care During an Influenza Pandemic: Issues and Resources*
<http://www.pandemicflu.gov/plan/healthcare/homehealth.html>
- AHRQ's suite of emergency preparedness resources, go to: <http://www.ahrq.gov/prep/>
- If you have a question about utilizing AHRQ resources please e-mail us at: emergencypreparedness@academyhealth.org
- A recording and transcript for today's event will be available at a later date at <http://www.ahrq.gov/prep/>

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Thank you!

- Thank you for joining us today!
- Please take a moment to fill out the feedback form when you close your screen.