

1 **2.0 Concept of Operations**

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3 **Levels of Activation**

4 The State of New Hampshire operates on four different levels of activation for all events,
5 including public health emergencies. These levels are implemented at all emergency operation
6 centers including the SEOC, ICC, Public Health Operations (PHOps) and MACEs.

7
8 **Level 1 – Monitoring or Normal Operations**

9 Monitoring daily situational awareness and assure responsiveness in anticipation or occurrence
10 of an emergency incident or large-scale event that may require staff support. The primary
11 direction and control function at Level 1 is maintained at the State level and includes a 24/7
12 warning point. This provides for a notification process that allows for further activation
13 decisions to be made. At the regional level, the Public Health Region (PHR) Coordinator or
14 Emergency Preparedness Coordinator maintains established links for communication with the
15 State and region.

16
17 **Level 2 – Low Intensity**

18 A low intensity event will require select personnel to monitor the event, collect information and
19 keep appropriate partners briefed. At the regional level, primary responsibility typically falls to
20 the PHR Coordinator or Emergency Preparedness Coordinator. Select partners may be present
21 in emergency operations centers at both state and regional levels.

22
23 **Level 3 – High Intensity**

24 The situation requires, or is likely to require, a high level of response from the State and local
25 agencies. The event could have the potential to result in a significant loss of life, property
26 damage, and/or the disruption of vital public safety infrastructure. All pertinent emergency
27 operations centers are fully activated. There is anticipation that the incident may require multi-
28 day activation.

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30 **Level 4 – Complex, High Intensity Event**

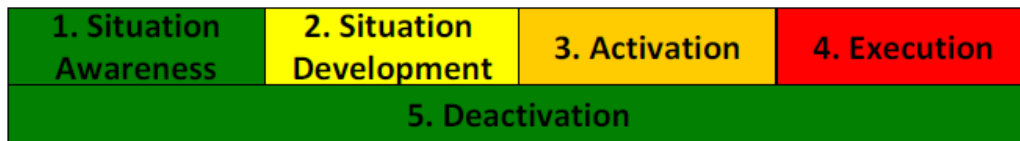
31 A complex, high intensity event has or is likely to occur that will require significant State and
32 possibly federal response. This has all the attributes of a Level Three but is more complex either
33 because a larger geographic area is affected, or because the potential effects are or will be
34 greater. It is more likely to result in a Presidential Declaration.

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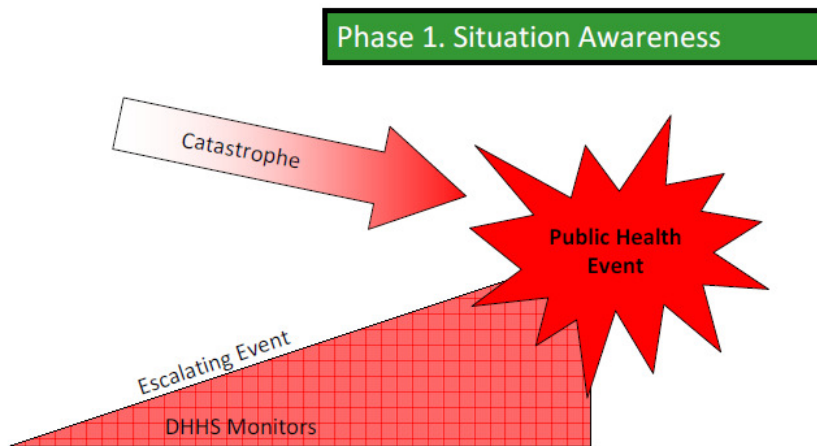
Phases of Operation

The Concept of Operations for a Public Health emergency in the State of New Hampshire is based on a 5-phase approach. The different phases are Situation Awareness, Situation Development, Activation, Execution and Deactivation. All have a starting point and a trigger to move into the next phase. While each phase covers a different piece of an SNS event, it is imperative for the incident planners and command staff to be thinking at least one phase ahead at all times. The deactivation phase should be part of initial planning functions and the Incident Action Plan (IAP).



All agencies involved in a Public Health emergency will maintain a disaster log of the event making use of the State disaster management software when available, as well as a disaster response record documenting their incident-related expenditures.

Phase 1 – Situation Awareness



Two types of conditions could cause a Public Health Event that would result in the activation of PODs: 1) a sudden catastrophe, such as hurricane, terrorist attack or radiological event; or 2) an escalating event that would take place over a course of time determined by public health staff through assessment of data collected through disease surveillance systems.

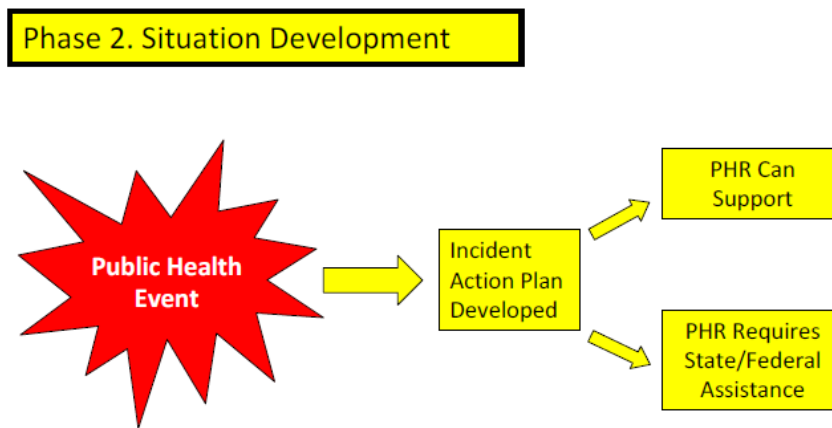
During Situation Awareness, State officials will be monitoring regional activity looking for any unusual medical/public health activity such as a dramatic increase in emergency room visits

1 with patients exhibiting the same symptoms or in-state pharmacy resources being depleted. At
2 this time, all state Operations would be at a Level 1.

3
4 It can be expected that the need to open PODs will be identified when public health officials
5 identify the occurrence of a major health emergency and the normal inventory of drugs and
6 medical supplies will be insufficient to meet the anticipated demand.

7
8 Determining or recognizing that a public health event has occurred is the trigger point into
9 Phase 2: Situation Development.

10 11 **Phase 2 – Situation Development**



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13
14 One of the first priorities in a Public Health Event is to develop an IAP. This will require a
15 convening, either physically or virtually, of pertinent partners to discuss the current
16 situation and develop an IAP. These partners, at a minimum, will include PHR Coordinator,
17 Local Emergency Management Directors, Hospital Liaison, and other public health or local
18 officials. The IAP will determine whether the region will be able to self-support the incident
19 or whether it could have the possibility of overwhelming pharmaceutical and medical
20 materiel response assets and assistance from the State or CDC is necessary. At this time all
21 state Operations would be, at a minimum, at a Level 2.

22
23 The decision to request SNS or other State assets will be a collaborative effort among local,
24 regional, and State officials. The decision will begin at the local level when officials identify a
25 potential or actual situation that they believe has the potential to threaten the health
26 and/or safety of their community.

27 28 **Requesting State Assistance**

29 The current Public Health Algorithm (v.Introduction, Figure 1) is used for requesting
30 assistance; however, it should operate as a dual process with communication going up and
31 down the public health chain simultaneously with emergency management communication,
32 especially if the event is identified via existing public health surveillance systems rather than
33 a more traditional incident that requires emergency management coordination at its onset.

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Regional and Local Resource Considerations for Requesting State Assets:

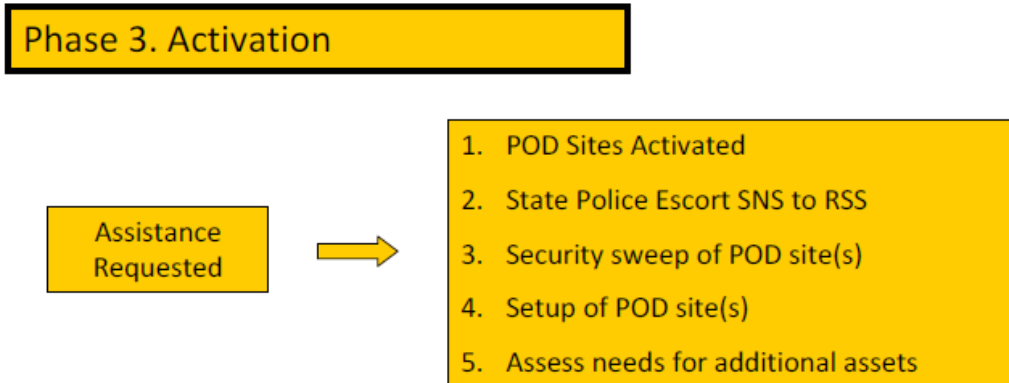
- Number of current casualties exceeding the local response capabilities available
- The projected needs of the population of the area (including transients and seasonal surge)
- The hospital surge capacity at the time of the event
- The availability of state resources including pharmaceutical distributors, oxygen distributor availability, nearby hospitals, and transportation services
- Local resources (e.g., pharmacy distribution, oxygen availability, and transport capacity)

Regions may request assets utilizing the Medical Supply Distribution Protocol. Requests will be received by the ICC and sent to PHOps for review/approval and then sent to the RSS warehouse for fulfillment of the order.

During this phase, the following other events may take place:

- A JIC may be established to coordinate all public information.
- The Governor may declare a “State of Emergency” or the commissioner of DHHS may declare a “Public Health Incident.”
- The SEOC may be activated and an event will be established in the disaster management software.
- MACEs will be activated

1 **Phase 3 – Activation**



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The Activation Phase of a POD event is in effect when assets have been officially requested and approved. At this time, all State Operations would be at a Level 3 or 4.

A. Notification to Open

1. Initial Capabilities

The capability to open a POD would initially rely on state and local resources. It would not involve federal resources, such as the SNS, unless the event fits the established criteria for requesting SNS as described in the *New Hampshire's Strategic National Stockpile Annex*.

2. Authorization to Open

The activation of PODs in New Hampshire will occur under the order of the DHHS Commissioner or his/her designee, though a coordinated discussion with the PHRs involved. When the decision is made by DHHS to open a POD, the regional POD plan is activated by contacting the appropriate PHR point of contact.

3. ICC/MACE Communications

Once the decision to open a POD has been made, the DHHS ICC will communicate with each regional MACE to initiate POD activation plans. ICC will communicate with the MACE all relevant information and decisions to ensure coordination of all emergency operations.

4. Activation Checklist

When the decision is made to open PODs, the POD plan is activated. The POD Activation Checklist should be utilized in collaboration between the MACE Operations Chief and the POD Manager (see Appendix 10E) to ensure all steps are completed in the process. These include:

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- a. Activate Incident Command System Structure:**
 - Activate the call-down systems for notifying the POD Manager and local POD team members.
 - Provide instructions to the staff on when and where to report, how their families will be protected, what hours they are expected to work, and any other pertinent information according to the local plan. Staff may need to report to a staging area instead of reporting directly to a POD site.

 - b. Notify the Following:**
 - Planning group (i.e., all hazard regional planning groups)
 - Political leaders
 - POD Facility(s)
 - Hospitals
 - Health care centers
 - Long-term care facilities
 - EMS (will they be utilized on-site and/or for transport?)
 - Visiting nurse agencies (identify staff who can assist)
 - Local fire, public safety, schools, civic organization
 - Volunteers
 - Neighboring communities

 - c. Arrange for the Opening of All Facilities to Be Used**
 - Notification to facility contact with date/time/duration of use
 - Notification to all vendors for food, supplies, etc,
 - Prepare to operate POD site.
 - Assess the need for additional assets
 - Review event-specific annex
 - Begin copying of all event-specific materials and signs OR contact business where arrangements have been made, so they can start printing the materials and signs

 - d. Provide Just-in-Time Training for All Volunteers.**
 - Provide each volunteer with a Job Action Sheet (JAS) for the position they will fill (see Appendix 8 for the complete list of JAS).
 - Note: JAS in Appendix 8 are a guide for regions to use as needed. Regions may add/eliminate actions within each JAS or chose not to fill each position depending on the incident.

 - e. Prophylaxis of Critical Personnel and First Responders**
 - Critical personnel and first responders may be prophylaxed, as State guidance allows. Distribution to family members of responders also may be included when appropriate and as available.

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- Coordinate with ICC for the time of opening to the public, and ensure opening time is consistent across the region/State.

5. Incident Action Reporting

It is critical that all POD operations be documented. An event log (ICS form 214, see Appendix 9) should be maintained to record POD operations. The log is used to record activities and events, which include, but are not limited to, requesting of SNS assets, opening and closing of the POD, shift changes, and other significant or major events. Job Action Sheets specify which forms should be utilized for each position. ICS forms can be found in Appendix 9, and can be downloaded at www.training.fema.gov/EMIWEB/IS/ICSResource.

B. POD Set-up

1. Set-up Team

The pre-identified POD set-up team should be dispatched to set up the POD and assist with initial operations. This set-up team should include a representative of the facility, if possible. Initial response resources should be managed by the POD Manager who will handle all command and general staff responsibilities. At some sites, a unified command may be established.

The set-up team should:

- Put up signs
- Set up client flow system
- Set up tables
- Arrange all supplies as needed
- Set up traffic flow system

2. Staff Arrival

When the call is made to open the POD, all staff scheduled to work at the POD opening should arrive in sufficient time to learn the POD layout, get their prophylactic medication or vaccination (as state guidance allows), be given just-in-time (JIT) training, receive their badge, be educated on the nature of the event, and be informed of any other agent-specific guidance that is required. The POD Manager will report available number of staff to the MACE, which will then be communicated to the ICC upon request. The MACE Operations Section Chief will work with POD Manager(s) to help coordinate the availability of staff and help schedule shifts to ensure sufficient deployment of POD staff.

3. Receipt of SNS Assets

In accordance with the State SNS-RSS plan, the appropriate SNS inventory will be delivered to the POD. The law enforcement escort for the delivery will contact the POD site when they are approximately 5-10 minutes from arrival. The designated person at the POD will sign for the inventory. If the driver is not returning to the RSS

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1 immediately, the signed inventory receipt will be faxed to the RSS as soon as
2 possible. The POD Manager will notify the MACE upon receipt of the SNS assets.
3

4 **4. Ready to Open**

5 When the POD is ready to open, a test run should be done by sending the staff
6 through the POD. This allows for a preliminary check of the site and the proper
7 prophylaxis of staff prior to opening up to the public. The POD Manager will
8 communicate with the MACE when the POD is ready to open. All communications
9 with the MACE should be documented using ICS Form 214 (see Appendix 9, Forms).
10 It is important that the ICC is aware that the POD is operational. A large-scale and/or
11 statewide event may require multiple PODs to be opened. In that case, coordination
12 for the opening of the PODs is essential. DHHS will recommend the time at which
13 the PODs should be opened and it will offer technical expertise and assistance as
14 appropriate. The information and assistance will follow the ICS activated for the
15 event. A status report should be provided regularly to the MACE on staffing needs,
16 population served, and inventory status. All requests for additional resources are
17 coordinated through the MACE to ICC.
18

19 **C. Finance and Administration**

20 Time keeping, procurement, cost accounting, and the management of client records are
21 the primary functional activities of this section. Finance and administration functions will
22 be coordinated at the MACE through the Finance and Administration Section Chief who
23 will report directly to the MACE Manager.
24

25 **1. Personnel Time Keeping**

26 Staff time must be accurately documented to receive State and federal reimbursement.
27 Staff time keeping should be the responsibility of the POD Manager (see Appendix 9,
28 Forms).
29

30 **2. Compensation/Claims Unit**

31 Since all emergencies are first considered local events, the responsibility falls on the
32 local jurisdiction for costs associated with the response. These costs can drain local
33 resources. Compensation may be available in certain circumstances. In the case of a
34 federally declared emergency, federal funds may be made available to reimburse costs.
35 All expenditures associated with maintaining site operations must therefore be tracked.
36

37 **3. Procurement/Cost Unit**

38 It is important to track all expenditures associated with the event, including hours
39 donated by volunteers. Following the deactivation of the POD, an after-action report
40 will be prepared to account for POD-related costs. This report will be used for
41 documentation and reimbursement requests.
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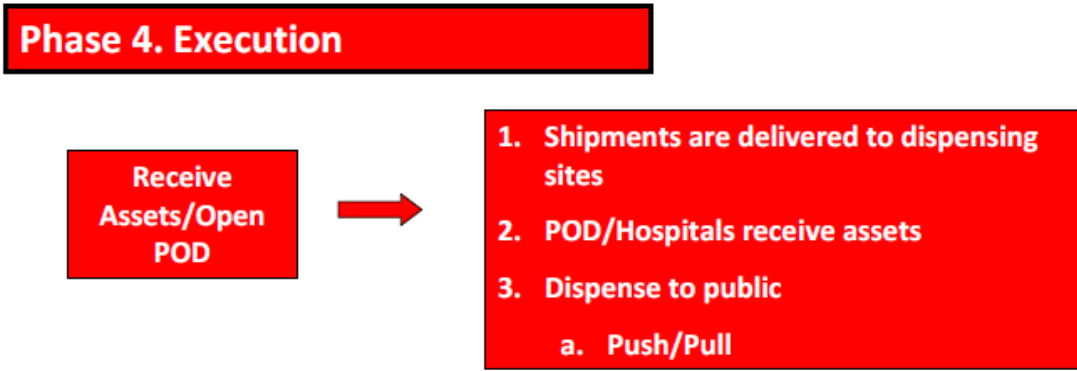
4. Client Data Entry

Client information to be collected and stored for data entry will be based on the identified threat. At a minimum, it will include demographic information, medication/vaccine information, and permission/authorization documentation.

Tracking and identification systems allow for accurate, unduplicated client counts and also prevent clients from being processed more than once. All client information managed at the POD will be afforded the same level of confidentiality as other health records as identified in the Health Insurance Portability and Accountability Act (HIPAA).

Client information can be processed at the site or at a designated off-site location. If the information is entered on-site, the room designated for processing should have the required resources and space for the number of staff needed to complete data entry. If processed outside of the POD, client forms will be collected, batched, and sent to data processing. This will avoid the dependence on continuous on-site Internet access.

1 **Phase 4 – Execution**



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3 **A. Opening**

4 DHHS will provide information to the MACE(s) as to the time the POD(s) are to be opened to
5 the public. This will trigger the execution phase.

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7 **Proof of Residency/Identification Requirements**

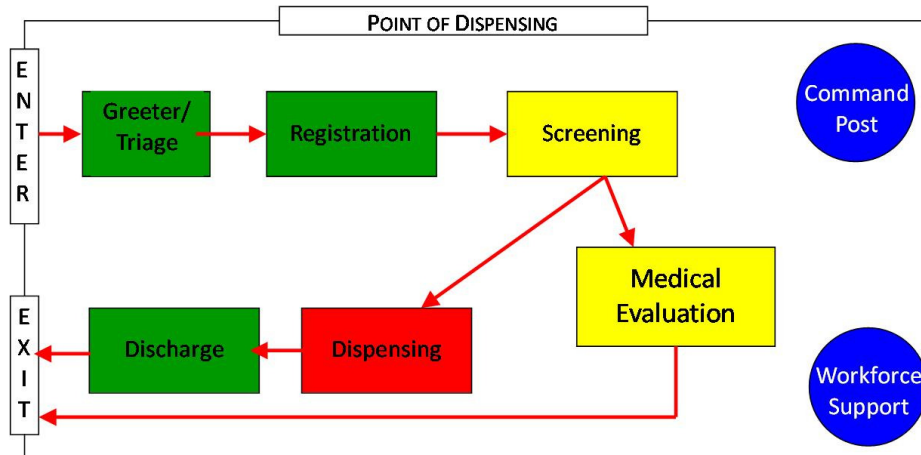
8 New Hampshire does not require proof of citizenship or residency to receive medication
9 during a Public Health Emergency. DHHS will ensure through either the Public Information
10 Office or at the JIC to ensure that public messages are clear that everyone is eligible to
11 participate. Identification is not required at PODs unless to verify age for adult/guardian
12 consent.

13
14 **Priority Groups**

15 The Division of Public Health Services (DPHS) through PHOs will determine who the priority
16 groups will be to receive medication during an event. Provisions will be made for this group
17 prior to the opening of public clinics. This priority may include, but not be limited to, first
18 responders, health care providers, and their families.

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20 **B. Stations**

21 **1. Client Flow**



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2 Taking stock of how the POD will flow assists in achieving the maximum efficiency of the
3 POD. To maintain an effective and efficient flow of clients through the POD, it may be
4 necessary to intervene and alleviate potential problems. All POD personnel have the
5 responsibility of ensuring that the POD functions efficiently and that clients are handled
6 rapidly in a safe manner.

7
8 Signs of possible bottlenecks or backlogs:

- 9 ○ Clients becoming upset/vocal in line
 - 10 ○ Clients pushing in line
 - 11 ○ Clients becoming symptomatic while in line
 - 12 ○ Unnecessary talking between staff and clients
- 13 (see Appendix 12b Training - Behavioral Health Tips)

14
15 Bottlenecks or backlogs may be remedied through non-medical changes at the POD by
16 tasking or reassigning staff to various stations to relieve problem areas quickly. The
17 POD manager has the authority to make non-medical decisions to relieve the problem
18 areas. Any POD flow changes that involve protocols, orders, or other medical functions
19 need to be processed through the MACE medical control and potentially through
20 DHHS.

21
22 **2. Entrance/Greeting/Registration**

23 Greeters start the client screening as clients arrive at the POD. All individuals are
24 observed to identify functional needs or individuals who visibly appear sick. Clients who
25 appear sick should be triaged before entering the POD facility and referred to a clinician
26 or a treatment facility. Clients with functional needs are quickly assessed and provided
27 the appropriate assistance. Healthy individuals who do not have completed forms are
28 given a registration form and directed to the Forms Completion Area. Individuals with
29 completed forms are directed to Forms Review.

30
31 Staff should be in the Forms Completion Area to provide assistance to clients filling out
32 the forms. This includes providing instructions on how to complete the forms, answering
33 questions, and directing individuals to the Form Review Station.

34
35 **3. Forms Review**

36 Forms review is a continuation of client screening. Completed registration forms are
37 reviewed to identify any contraindications to the standard medication/vaccination that
38 is being provided. If there is no contraindication identified, the client then proceeds to
39 dispensing. Clients will be identified through forms review if they should not receive the
40 standard medication or dose. These clients are directed to the Medical Evaluation
41 section of the POD for identification of the appropriate treatment.

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1 **C. Dispensing**

2 **1. Oversight**

3 A pharmacist or an MD should oversee the dispensing/vaccination. They may be located
4 at the MACE, overseeing a number of PODs, or at a specific POD. With any medication,
5 adverse reactions can occur, and emergency medical personnel and supplies must be
6 available to treat any that may occur at the POD, such as anaphylactic reactions.

7
8 **2. Dispensing/Vaccine Administration**

9 Staff are responsible for the following activities:

- 10 • Verify/review the medical screening form before administering
- 11 medication/vaccine
- 12 • Provide clients an opportunity to ask remaining questions
- 13 • For vaccine administration, ensure that vaccines are administered according
- 14 to the CDC's Advisory Committee on Immunization Practices recommended
- 15 procedures
- 16 • If a client refuses to be vaccinated, direct him/her to the education area to
- 17 sign a refusal form
- 18 • Document the medication and dosage given on the client registration form
- 19 • Collect registration forms
- 20 • Provide instructions to client regarding post-care of vaccination site
- 21 • Direct client to Exit Area (or other services, if needed)
- 22

23 **3. Standing Orders**

24 The State Epidemiologist, or designee, will be responsible for writing State
25 medical/standing orders for the incident. Medical/standing orders for each event/agent
26 will determine the distribution plan. Drafts or samples of these medical orders and clinic
27 protocols may be developed in advance, but the epidemiology and details of the incident
28 will determine the specific medical orders and clinic protocols for each situation.

29
30 **4. Authorized Dispensing Personnel**

31 The below RSA's outline current laws for dispensing medication, however in a State of
32 Emergency, the Governor can authorize certain exceptions.

- 33
- 34 a. RSA 318:42 advises prescription drugs shall be dispensed only by or in the presence of
35 and under the supervision of a pharmacist, physician, advanced registered nurse
36 practitioner, physician assistant, or registered nurse, as identified in RSA 318:42,VII (a),
37 in compliance with state and federal pharmacy-related laws and rules.
- 38
- 39 b. RSA 318:42 further defines physicians, dentists, optometrists, podiatrists, veterinarians,
40 advanced practice registered nurses, naturopathic doctors, midwives, and physician
41 assistants can possess, compound, personally administer, or distribute prescription
42 drugs to meet the immediate medical needs of their patients. It also allows the

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1 department of health and human services to possess and distribute “biological drugs” to
2 the public within the meaning of RSA 141-C:17.

3
4 c. The dispensing of non-controlled prescription drugs by registered nurses in clinics
5 operated by or under contract with the department of health and human services, or by
6 such nurses in clinics of nonprofit family planning agencies under contract with the
7 department of health and human services, provided that:

- 8 1. The drugs are dispensed under a written protocol established by a licensed
9 physician or by an advanced practice registered nurse, and approved by the
10 department of health and human services which provides for responsible
11 supervision over the activities in question and mentions the name of each
12 registered nurse for whom the physician or advanced practice registered nurse is
13 assuming supervisory responsibility. A written copy of the protocol showing the
14 date it was approved by the department of health and human services shall be
15 kept at the clinic at all times and shall be made available during any inspection
16 conducted under RSA 318:8.
- 17 2. The drugs appear on the current formulary approved pursuant to RSA 326-B.
- 18 3. The drugs are dispensed only to bona fide clients of the clinic for their personal
19 needs pursuant to written eligibility criteria established by the department of
20 health and human services.
- 21 4. The clinic, except for clinics operated directly by the department of health and
22 human services, possesses a current limited retail drug distributor's license
23 under RSA 318:51-b.

24
25 d. The possession, for emergency use only, by emergency medical care providers licensed
26 under RSA 153-A of such non-controlled prescription drugs as are specified by the state
27 emergency medical services medical control board, with the concurrence of the
28 pharmacy board, provided that there has been prior establishment of medical control
29 for possession of such drugs.

30
31 e. The emergency medical care provider may only administer such prescription drugs upon
32 receipt of orders to do so from a supervising physician or an emergency/trauma
33 advanced practice registered nurse. Such orders may be transmitted either directly or
34 by telephone or by radio or by other communication medium, or by standing order of
35 local medical control delineated in a protocol as defined in RSA 153-A.

36
37 f. 318-B:10 Professional Use of Narcotic Drugs. A practitioner other than a veterinarian, in
38 good faith, in the course of his professional practice, and for a legitimate medical
39 purpose, may administer and prescribe controlled drugs, or the practitioner may cause
40 the same to be administered by a nurse or intern under his direction and supervision. In
41 a bona fide emergency situation, the practitioner may dispense a controlled drug to a
42 patient under his care but only in a quantity not to exceed a 48-hour supply for all
43 schedule II substances or a 7-day supply of schedule III, IV, or V substances.

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2 g. Under Pharmacy Rules – Hospital Pharmacy Dispensing Ph 709.02 (C). An institutional
3 license shall permit the pharmacy to dispense medications to in-patients of the
4 institution, staff or employees of the institution, interim supplies of medication to
5 outpatients in emergency situations and home infusion therapy to contractual patients
6 not requiring hospitalization. If a pharmacist is on the premises, outpatient prescription
7 services may be provided by the pharmacy, on a one-time, no-refill basis, to an
8 ambulatory care patient and any patient who is being discharged with medications
9 related to the patient's hospitalization. Labeling for all outpatient prescriptions shall be
10 according to RSA 318:47-a and RSA 318-B:13, II.

11
12 h. Dispensing from Ambulatory Patient Treatment Area (i.e. ER) Ph 709.07 (a) In the
13 ambulatory patient treatment areas, a medical practitioner may dispense drugs for the
14 immediate needs of the patient, not in excess of a 72-hour supply, except that for
15 Schedule II controlled substances a maximum of 48-hour supply shall be allowed, if
16 permitted by the institution. However, the drug container shall be properly labeled.

17
18 **5. Investigational New Drug**

19 In the event that an Investigational New Drug (IND) or off-label drug is used, clients must
20 sign special IND consent forms and instructions for using IND's or off label drugs will be
21 provided by NH DHHS when applicable. Instructions and consent forms for use of IND's
22 and/or off label drugs will be provided with the recommended standing orders as
23 necessary.

24
25 **6. Unaccompanied Minor**

26 Every attempt should be made to contact the legal guardians of an unaccompanied minor
27 that arrives at the POD. If the legal guardians can not be contacted, the minor should be
28 provided the appropriate medication if the incident requires immediate treatment. The
29 minor's name, contact information and medication given should be documented for
30 possible follow-up at a later time. Emancipated minors (with or without their paperwork)
31 should be dispensed the appropriate medication in a public health emergency. (RSA 21:
32 44 defines the age of majority as 18. RSA 627: 6 defines the ability to administer medical
33 care to a minor.)

34
35 **7. Medical Evaluation**

36 Clients who have contraindications to the standard medication are sent to the Medical
37 Evaluation area for assessment and to determine what, if any, medications are
38 appropriate. Upon determination of appropriate medication at the Medical Evaluation
39 table, the client will be directed to continue through the POD process.

40
41 **8. Pediatric Dispensing/Vaccination**

42 A pediatric dispensing/vaccination workstation should be designated specifically for
43 families with children. Pediatric dispensing/vaccination will be able to dispense/vaccinate

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1 adults and pediatrics. Therefore, families can be processed together. Scales should be
2 available to weigh children to insure that proper dosage is calculated, if the weights are
3 not otherwise available. For pill dispensing, pediatric instructions will be provided at this
4 station for pill crushing and dosing.

5
6 **9. Express Line**

7 Clients are sent to the express line when no contraindications or functional needs are
8 identified. The clients directed to this line will receive the standard medication and then
9 exit the POD.

10
11 **10. Vaccination Administration**

12 Vaccination stations are set up to ensure ease of use. Supplies at each station will be
13 frequently restocked during operations. Staff responsible for delivery of supplies to each
14 station are also required to maintain safe and secure storage of vaccine at all times (i.e.,
15 ensure proper temperature). Stations should not be stopped from operating due to lack
16 of supplies. Supplies need to be delivered to each station without disrupting client flow or
17 the vaccination process. Ideally, dispensing stations are set up along a wall, with an aisle
18 between the wall and the dispensing table to allow for restocking supplies.

19
20 **11. Pill Dispensing**

21 Antibiotic/pill dispensing should be set up for maximum client flow. In a public health
22 vent that requires antibiotic dispensing, more than one kind of antibiotic may be
23 distributed.

- 24 • The majority of clients passing through a POD for antibiotics will receive the
25 standard antibiotic. These clients may pass through an express dispensing area
26 where only the standard antibiotic is dispensed.
- 27 • The head-of-household model allows for an adult family member to pick up all
28 doses required for their household. A client must provide the required registration
29 information for each dose being requested. If the required information is provided,
30 adequate doses shall be provided to treat their household members.

31
32 **12. Labeling**

33 Federal and State laws dictate specific information that must be included on the label(s)
34 of prescribed medication. Pills may come from the SNS in pre-filled unit-of-use bottles
35 with the Center for Disease Control and Prevention (CDC) label already attached,
36 including a portion of the label that can be peeled off and placed on the client's
37 registration form. In accordance with federal and State laws, each POD should be
38 prepared to add an additional label to the medication bottles with the following
39 information:

- 40 • Dispensing date
- 41 • Client's name
- 42 • Name and address of POD facility
- 43 • Prescriber's name

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- Name or initials of pharmacist-in-charge
- Prescription serial number

A duplicate of this label is placed on the registration form, next to the CDC label, for tracking and record purposes.

A labeling system may be provided by the State for POD use. This system uses the Avery address label (Style 5160). Incident-specific guidance will be provided by the State regarding need for and use of this system. In the event of a public health emergency, labeling laws may be waived. Instructions or exemptions on labeling requirements may be provided at the time of the event.

13. Exit

As clients exit the POD, last-minute questions are answered; further information and any educational materials are made available again. Clients who elected to not receive treatment may exit the POD, although client history forms are still collected. Clients may be directed to additional services, if necessary.

D. Additional Services

Clients may need services beyond the primary stations in the POD. Identify other locations within the POD to address the following:

1. Education and Information

- The education and information area should be readily accessible to all clients who desire more information on the agent, medication, or other issues directly related to POD operations and the ongoing public health event.
- Client education needs to provide current information regarding the disease, transmission, purpose of the medication, distribution, contraindications, and adverse reactions of the medication/vaccination recommended. This can be done through one-on-one counseling, signs, and flyers. Signs and flyers need to be placed where all clients can readily see and read them during the POD process. Signs and flyers need to be translated into the most commonly spoken non-English languages in the region.
- If a client refuses treatment, a refusal form needs to be signed indicating they have received relevant education, had their questions answered and are refusing the vaccine/medication at this time. If the agent is contagious and they are a contact to an identified case, they are to be instructed on appropriate quarantine measures, symptoms to monitor for, and how to get more information. Appropriate client contact information should be collected.

2. Behavioral Health

Behavioral health is not restricted to one particular area or station. Behavioral health workers may be assigned to a variety of stations, such as registration, education and

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1 information, security, transportation and waiting/check-out. Behavioral health workers
2 observe and monitor clients and staff for signs of fatigue and distress. They may utilize
3 psychological first aid techniques to calm someone down, discuss stress reduction
4 techniques, de-escalate aggravated behavior, provide accurate information, and provide
5 emotional support or direct individuals to additional resources. PODs should designate a
6 private area for 1:1 emotional support when necessary (see Appendix 12b, Training
7 POD- Behavioral Health Tips).
8

9 **3. Security**

10 Primary security operations and functions at POD sites are coordinated by local law
11 enforcement. During pre-event planning, a security plan was developed for each POD
12 detailing the procedures to be followed, to ensure the safety of volunteers, clients, and
13 medical supplies. Each POD Manager, in conjunction with the POD Security Officer, will
14 determine the number of security staff needed based on the security plan and the
15 specific incident. Security may be called upon to remove clients from the POD process
16 for the safety and security of the POD staff and other clients and should follow the “use
17 of force” procedures as outlined in the plan.
18

19 **4. First Aid Station**

20 A specific area in the POD is needed to provide treatment for injured/sick clients or
21 staff. First aid staff will assess and assist the injured or ill individual. If the individual
22 requires further medical attention they should be directed to the nearest medical
23 facility. Basic first aid supplies will be available at the first aid station and pre-event
24 planning will have identified the EMS personnel and ambulance service that will be
25 utilized. All incidents will be documented by the first aid staff and reported to the POD
26 Manager.
27

28 **E. Clients with Functional Needs**

29 A diversity of clients with a range of functional needs will be seen in a POD, including but not
30 limited to: the elderly; individuals with physical and/or cognitive disabilities, some who may
31 be accompanied by service animals; non-English speakers; and children. All sites must be
32 accessible as required in Title II of the American Disabilities Act (ADA) and have plans in place
33 to assist individuals’ with functional needs through the POD. Written materials will be
34 provided by the CDC and/or DPHS for those who are non-English speaking. People with visual
35 impairments, if not accompanied by a family members, direct support provider or friend, will
36 be assisted through the clinic process by a designated staff member.
37

38 Clients who arrive at the POD and require assistance may be identified in the waiting and
39 greeting areas. POD staff should identify themselves and escort those clients and their
40 caregiver/family member to a pre-designated area for assistance.
41

42 Each POD should have a plan in place for translation needs including American Sign Language
43 (ASL). While having an interpreter on site is ideal, the NH Department of Safety, Bureau of

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1 Emergency Communications, 911 Public Safety Answering Point (PSAP) has made
2 arrangements for 24/7 emergency translation services. The services can be reached through
3 the PSAP Supervisor at 603-271-8000. Signs within the PODs and Treatment Centers should
4 include languages other than English that are representative of the region. The languages
5 needed, based on New Hampshire’s population – include Spanish, French, Cambodian,
6 Portuguese, and others. We anticipate a great need for patient information and registration
7 forms in alternate languages. If available, New Hampshire will rely on CDC for translated
8 documentation, however NH DHHS also has a contract in place for JIT translation needs
9 during a public health emergency.

10
11 Signs within the PODs and Treatment Centers should include languages other than English
12 that are representative of the region. See Appendix 3 for a language identification chart that
13 can be used to help identify languages spoken.

14
15 The CDC does not have information available for people with a low literacy level. POD forms
16 are written so that clients of varied reading levels will be able to understand and fill them
17 out. Because clients with a low-literacy level may be hesitant to ask for additional assistance,
18 clinic staff will be providing adequate verbal information so that all clients will understand
19 the necessary information.

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