

1 **1.0 Pre-Event Planning**

2  
3 This POD SOG utilizes an “all health hazards” approach, with local, state and federal planners  
4 working towards readiness for any public health emergency event. Specifically, this section  
5 provides planning recommendations relative to POD facilities, organizational structure, staffing  
6 and personnel, and public information and communication.

7  
8 It is important to distinguish between planning that needs to occur before an actual POD is  
9 needed and the planning function within the MACE during a response to a public health  
10 emergency. This section focuses on former.

11  
12 POD Plan development should be based on “Estimated New Hampshire population data, 1990  
13 to 2010” prepared by the Office of Health Statistics and Data Management Section within the  
14 Division of Public Health Services. In addition to the residential population for each region and  
15 POD site, planners should attempt to account for seasonal and workforce surge populations.

16  
17 A POD plan should account for residential, business, and seasonal populations, as dispensing  
18 may be recommended to an entire population or a smaller subset or group of people.

19  
20 **Planning Team**

21 Planning for POD operations primarily occurs on a local or regional level through coordination  
22 with the State’s PHRs. It is essential to begin the planning process well in advance of any actual  
23 emergency or event.

24  
25 Local and/or regional POD planning teams should include representatives from the following  
26 disciplines/sectors:

- 27 ○ Public Health
- 28 ○ Behavioral Health (mental health, substance abuse, and social service)
- 29 ○ Emergency Management
- 30 ○ Public Safety
- 31 ○ Hospitals/Alternate Care Facilities
- 32 ○ EMS/Fire
- 33 ○ Community Emergency Response Team (CERT)
- 34 ○ Medical Reserve Corps (MRC)
- 35 ○ Healthcare (Home Health/Visiting Nurses, Physicians and Pharmacists)
- 36 ○ Organizations Servicing At-Risk Populations
- 37 ○ Schools (colleges, universities, public and private schools)
- 38 ○ Private Businesses and Professional Organizations
- 39 ○ Volunteer and Civic Organizations
- 40 ○ Faith Based Organizations
- 41 ○ Child Care Organizations

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1 The Planning Team should meet, at a minimum, on a quarterly basis to insure capturing any  
2 issues that might impact the plan. Minutes of these meetings should be documented. A plan  
3 review should be conducted annually.

4 **Points of Dispensing**

5 **1. POD Goals**

6 The primary goal of a POD is to provide for the timely dispensing of medication to the  
7 affected population as recommended by the Department of Health and Human Services  
8 (DHHS). POD plan development should utilize an “all health hazards” approach to  
9 planning, with local, regional, and state planners working towards readiness for a range  
10 of possible public health events. PODs may be called upon to mass dispense medications  
11 to all individuals who arrive at the POD, or they may be called upon to provide  
12 medications to a targeted population as directed by DHHS. POD plans should use  
13 population data as a planning tool, but implementation may not be exclusive to the  
14 residential population. Final guidance will be released by DHHS at the time of the event  
15 and it will be event specific.

16  
17 **2. POD Selection Criteria**

18 Statewide POD facilities are selected, under guidance from the SNS Coordinator, by the  
19 appropriate PHR based on population, geographical locations and a facility assessment  
20 (See Appendix 10A, Response Clinic Site Assessment).

21  
22 Once a facility has been selected as a POD site a *Response Clinic Delivery Profile* should  
23 be completed and submitted to the SNS Coordinator (See Appendix 10B, Response Clinic  
24 Delivery Profile). Coordination of all POD sites within a region during an event, which  
25 includes managing contingencies caused by shifts in population, availability of staff, and  
26 variations in resource allocation, will be accomplished through the regions MACE.

27  
28 **3. Strategic National Stockpile Assets**

29 The mission of the SNS Program is to maintain a national repository of life-saving  
30 pharmaceuticals and medical material, which will be delivered to the site of a chemical,  
31 biological or radiological terrorism event, or other man-made or natural disaster, in  
32 order to reduce morbidity and mortality in civilian populations.

33  
34 The SNS consists of nationally pre-positioned medical and surgical material, supplied by  
35 the Centers for Disease Control and Prevention (CDC) to aid state and local emergency  
36 response authorities, who have exhausted local supplies due to an act of terrorism or  
37 other disaster. The SNS contains medications and medical/surgical supplies designed to  
38 enhance response to terrorist attacks employing nerve agents (organophosphates) and  
39 other biological agents such as anthrax, plague, tularemia, or naturally occurring  
40 disease. SNS will arrive in New Hampshire by air or ground.

41  
42 The State of New Hampshire has developed plans to support local/regional POD  
43 operations. This includes a plan for the deployment of SNS assets to hospitals and POD

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1 sites. Pre-event planning should include how these assets will be requested from the  
2 appropriate MACE, who is authorized to accept these assets at the POD site and how the  
3 inventory will be managed (See Appendix 9, Forms for examples of invoice and order  
4 forms).

5  
6 The New Hampshire Strategic National Stockpile Annex is a supplement to ESF-8 under  
7 the State Emergency Operations Plan (SEOP) and follows NIMS guidelines. The annex  
8 addresses management responsibilities in an emergency situation for State-level  
9 organizations to facilitate a system to quickly deliver critical medical assets. The primary  
10 goal is to coordinate State agency efforts on the use and management of the SNS in the  
11 event of a public health event, terrorist attack, natural disaster, or technological  
12 accident.

13  
14 The SNS annex will be activated when critical medical supplies in the state are  
15 insufficient or anticipated to be insufficient to respond to a public health emergency.  
16 Such an event could be immediate, evolving, or anticipated as a result of terrorist  
17 attacks, disease outbreaks, major natural disaster, or industrial accidents.

18  
19 **4. Closed PODs**

20 Closed PODs are locations in the community that are designated for pick up of  
21 medication to enable a group of people to self-medicate who would otherwise have to  
22 make special arrangements to travel to a POD. Generally these sites may serve  
23 segments of the population that are not easily mobile or have special needs that would  
24 make travel to a POD difficult or impossible. Closed PODs must have medical or  
25 pharmacy personnel capable of dispensing to facility population, staff, and others as  
26 locally designated.

27  
28 These sites are pre-designated locations, and regional partners are responsible for  
29 providing education and coordination on mass dispensing operations. Closed POD  
30 templates and documentation have been created to assist with planning.

31  
32 Closed POD facilities, such as prisons and jails, long-term care facilities, and other  
33 residential facilities, will not receive direct shipments of SNS supplies. These facilities  
34 may be responsible for dispensing operations for their employees and/or  
35 residents/inmates/patients. POD planners should contact such facilities to insure that  
36 their plans include a process to obtain their allocation of SNS supplies from the  
37 appropriate POD (see Appendix 10D, Closed POD Operational Plan).

38  
39 Additionally, local and regional planners need to communicate with colleges and  
40 universities, military installations, and any other residential facilities/institutions to  
41 determine the need to include their residents in the community POD plan. Plans should  
42 also include populations with functional needs, including the elderly, those with  
43 disabilities, those with serious mental illness, pharmacological dependency, minority

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1 populations, non-English speaking populations, and children, including those in private  
2 schools. Additionally, individuals who are homebound need to be identified as well as  
3 how they will be serviced. Agencies and groups who work with these populations may  
4 be utilized.

5  
6 **5. POD Safety/Security**

7 A POD site safety and security plan should be developed that details policies and  
8 procedures for coping with safety and security situations and actions to be taken to  
9 protect people, property, and SNS assets. The safety and security plan should include the  
10 process for assigning tasks and outline protective actions that will be implemented. The  
11 site safety and security plan should be consistent with the POD operations plan and ICS  
12 structure.

13  
14 Local law enforcement will coordinate POD site security and protection of staff and  
15 clients, as well as perform other law enforcement duties. In addition to sworn law  
16 enforcement personnel, the “security detail” may be comprised of private security  
17 personnel or volunteers who are trained in traffic control and/or crowd control. Law  
18 enforcement personnel should be the lead planners when designing POD security  
19 operations (see Appendix 10A, Response Clinic Site Assessment). The POD site safety  
20 and security plan will provide for the following:

21  
22 **a. Security Needs Assessment**

23 The plan should include how a determination of the level of security necessary to  
24 support POD operations will be made when a POD is activated, ensuring that at  
25 least one dedicated law enforcement resource (officer and vehicle) is present  
26 and visible at each POD.

27  
28 Involvement of law enforcement personnel in POD plan development will better  
29 ensure that POD security issues can be incorporated into the daily law-  
30 enforcement activities when a facility is operational.

31  
32 Since a large number of individuals will be proceeding through the POD,  
33 establishing appropriate security measures will ensure that individuals do not  
34 gain access to areas within the POD without approved identification.

35  
36 Exterior and interior physical security of the POD facility should be addressed to  
37 insure protection of staff and clients as well as security of inventory, including  
38 locked and limited access to SNS assets, and the protection of vital records. POD  
39 security plans should also provide for secured transport of SNS assets when they  
40 are moved between locations. This assessment should also include how a breach  
41 of security will be handled (see Appendix 10A, Response Clinic Site Assessment).





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1 provides for maximum flexibility in varied situations, however specific training is  
2 recommended for command staff (see Appendix 12, Training and Evaluation)

3  
4 **c. Command Staff**

5 The POD command system includes, at a minimum, the following positions. The  
6 scope and resources of each POD will dictate how these roles expand or contract.  
7 POD planners should identify back-up personnel, with contact information, to fill  
8 these roles if the assigned individual is unavailable.

- 9  
10
  - POD Manager
  - POD Health and Safety Officer
  - POD Liaison Officer
  - POD Security Officer
  - Clinical Group Supervisor
  - Non-Clinical Group Supervisor
  - Workforce Support Group Supervisor

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12  
13  
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15  
16  
17  
18 A POD Organizational/Staffing Chart is found in Appendix 2 and the Job-Action-  
19 Sheets outlining the duties and responsibilities of these positions are found in  
20 Appendix 8.

21  
22 **d. Volunteer Recruitment**

23 Volunteers are classified as affiliated or unaffiliated. Unaffiliated volunteers may  
24 also be called spontaneous volunteers. These volunteers are not part of a  
25 recognized volunteer agency and often have no formal training in emergency  
26 response. They are not officially invited to become involved but are motivated by  
27 a sudden desire to help others in times of trouble. Unaffiliated volunteers who  
28 arrive at a POD during an emergency should be referred to the MACE for  
29 processing and credentialing.

30  
31 Affiliated volunteers are attached to a recognized volunteer or nonprofit  
32 organization and are trained for specific disaster response activities. Their  
33 relationship with the organization precedes the immediate disaster, and they are  
34 invited by that organization to become involved in a particular aspect of  
35 emergency management (see Appendix 7, Volunteer Resources).

36  
37 **e. Call Down List**

38 If an emergency response is required, it is imperative that staff and volunteers be  
39 quickly contacted. Therefore, a call down list will be developed and maintained  
40 that provides for notification of these individuals on a 24/7 basis.

41  
42 The call down list shall be updated and exercised quarterly.  
43



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1  
2 Fact sheets, hotline numbers, and other event-specific information will be  
3 provided by the State of New Hampshire at the time of the event. DHHS is also  
4 responsible for developing the follow-up messages to ensure medication  
5 compliance. Each PHR should have the capability to reproduce these materials  
6 within the region as needed.

7  
8 **c. Methods of Dissemination**

9 The NH DHHS Public Information Office has the primary responsibility for  
10 communicating with the public and partners during a bioterrorism or health-  
11 related crisis. This information may be released from DHHS or the Joint  
12 Information Center (JIC) if one is established. The DHHS PIO will work with the  
13 MACEs to help other PIOs at the regional and local level understand the situation  
14 and its impact.

15  
16 The MACE PIOs are responsible for conducting public information activities for  
17 local jurisdictions within their regions during an event and, in conjunction with  
18 the POD Manager, communicating with the public by utilizing local media, flyers  
19 and posters, and other methods of providing local information.

20  
21 PIOs at the MACE should be easily identifiable. Information inquiries from the  
22 media or the public about POD operations and services should be directed to the  
23 MACE PIO. In the event that the POD is authorized by the MACE to release  
24 information, an area should be designated for private interviews and press  
25 conferences. It should be removed from the activities of the POD operations to  
26 promote client confidentiality. Questions of a clinical nature should be referred  
27 to an onsite Medical Director or to the PIO at DHHS.

28  
29 **d. At-Risk Population Information Needs**

30 Accessibility of information and services should be considered and addressed in  
31 a POD plan. Before, during, and after an incident, members of at-risk populations  
32 may have additional needs in one or more of the following functional areas:  
33 communication, medical care, maintaining independence, supervision, and  
34 transportation. In addition to those specifically recognized as at risk in the  
35 Pandemic and All Hazards Preparedness Act (PAHPA) (i.e., children, seniors, and  
36 pregnant women), individuals who may need additional response assistance  
37 include those who have disabilities, live in institutionalized settings, are from  
38 diverse cultures, have limited English proficiency or are non-English speaking, are  
39 transportation disadvantaged, have chronic medical disorders, and/or have  
40 pharmacological dependency. Organizations working with these populations  
41 should be consulted during the development of the POD plan.

1  
2 **8. Memoranda of Understanding**

3 A memorandum of understanding (MOU) should be developed, signed, and reviewed  
4 annually between the PHR and all facilities, agencies, and companies that will play a role  
5 in the response. The purpose of an MOU is to identify resources and detail how they  
6 may be used in response to a public health emergency. Examples of MOUs that could be  
7 completed to support POD operations include: facility use agreements, transportation  
8 services (buses), copy services, and materials sourcing (medical and clerical supplies).  
9 See Appendix 5 for recommended guidelines for writing an MOU.

10  
11 **9. Personnel Badge and Identification**

12 An identification protocol for staff should be in place prior to the opening of the POD.  
13 Trained staff members should be pre-identified to operate the badging system that is  
14 used within the region. Equipment should be checked for functionality and to ensure an  
15 adequate supply of identification card stock, for example Baudville #43879 card stock.  
16 Additionally, plastic card holders, lanyards, software, and a method to take just-in-time  
17 digital photographs should be made available. For personnel working at the POD site  
18 that have identification badges such as police, fire, E.M.S., and other health care  
19 workers, provisions should be made to provide specific job functions they will be  
20 performing at the POD. This could include using blank card stock and writing in the title  
21 of the job function once it has been identified by the appropriate unit leaders.

22  
23 Examples of qualified identification badges may include the following:

- 24 • Driver's license
- 25 • Photo identification from an employer
- 26 • Photo identification from a registered MRC Unit
- 27 • Photo identification from a registered CERT

28  
29 Badging of staff working at the POD is required to assure that appropriate individuals  
30 are performing their designated job functions. Name badges may include the following  
31 information.

- 32 • Name of individual
- 33 • Location and type of duty assignment
- 34 • Expiration Date
- 35 • Event specific (name and location of the event for which for which the POD is  
36 opened).

37 Badges should differentiate clinical, non-clinical and workforce support staff.

38 The State of New Hampshire has approved the purchase of a standard badging system  
39 for use by PHRs statewide. The system, Baudville ID Maker® QuickCam bundle, prints IDs  
40 on 3 1/8" x 1 7/8" credit card size card stock and includes laminating pouches.

41  
42 NOTE: Medical professional volunteers who will be working within the scope of their  
43 professional license in a POD are more easily cleared for service if they have been

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1            deployed from a DMAT, MMRS, MRC, or through ESAR-VHP as these organizations  
2            require credential verification.

3  
4            **10. Personnel Support Services**

5            Plans must be in place for the appropriate care of those who are working at the POD.  
6            These plans include procedures for taking breaks, rotating staff through operational  
7            periods, communications with family, use of behavioral health services and the provision  
8            of meals and/or snacks for the staff. A dedicated staff first aid station should be  
9            identified in case a staff worker becomes ill or injured. This first aid station should be  
10           staffed by certified/licensed EMS personnel or other medical personnel trained in  
11           emergency care.

12  
13           **11. POD Set-Up**

14           A POD set-up team should be pre-identified and be able to be quickly dispatched to set  
15           up the POD and assist with initial operations. This set-up team should include a  
16           representative of the facility, if possible.

17           The set-up team has the minimum responsibility of:

- 18                • Putting up signs
- 19                • Setting up client flow system
- 20                • Setting up tables
- 21                • Arranging all supplies as needed
- 22                • Setting up traffic flow system

23  
24           **12. POD Deactivation**

25           The POD deactivation plan outlines the process for deactivating POD operations and  
26           closing the site. The plan should include the following:

- 27                • A process for deactivating staff, including instructions for each POD position on  
28                deactivation procedures (listed on Job Action Sheet).
- 29                • A process for counting and returning remaining inventory and unused supplies to  
30                their originating source, including SNS resources per guidance from the State.
- 31                • Actions for returning the facility to its original condition, purpose, and ownership,  
32                including a process for documenting property damage and cleaning and  
33                disinfecting surfaces as recommended.
- 34                • A process to notify the public about POD deactivation and alternate means of  
35                obtaining prophylaxis once the POD has closed.
- 36                • A means for the safe collection, removal, and disposal of biohazard waste.