Pharmacy’s Role in Emergency Management

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Objectives

- Implement a Family Emergency Plan.
- Recognize which type of emergencies would disrupt normal operation of the pharmacy and outline a contingency plan that would allow pharmacy operations to proceed in the event of one
- Describe strategies used to asses the pharmaceutical needs of displaced people and for meeting the needs identified.

Your Family Emergency Plan

Making A Plan

Step 1: Put together a plan by discussing these 4 questions with your family, friends, or household to start your emergency plan.

1. How will I receive emergency alerts and warning?
2. What is my shelter plan?
3. What is my evacuation route?
4. What is my family/household communication plan?

Step 2: Consider specific needs in your household.

- Different ages of members within your household
- Responsibilities for assisting others
- Locations frequented
- Dietary needs
- Medical needs including prescriptions and equipment
- Disabilities or access and functional needs including devices and equipment
- Languages spoken
- Cultural and religious considerations
- Pets or service animals
- Households with school-aged children

Step 3: Fill out a Family Emergency Plan

Download and fill out a family emergency plan or use them as a guide to create your own.

• Emergency Plan for Parents (PDF)

Write your family's name above

Family Emergency Communication Plan

FEMA P-1095 / July 2017

HOUSEHOLD INFORMATION

Home #: ....

Address: ....

Name: .... Mobile #: ....

Other # or social media: .... Email: ....

Important medical or other information: ....

Name: .... Mobile #: ....

Other # or social media: .... Email: ....

Important medical or other information ....

Name: .... Mobile #: ....

Other # or social media: .... Email: ....

Important medical or other information: ....

Name: .... Mobile #: ....

Other # or social media: .... Email: ....

Important medical or other information: ....

SCHOOL, CHILDCARE, CAREGIVER, AND WORKPLACE EMERGENCY PLANS

Name: ....

Address: ....

Emergency/Hotline #: .... Website: ....

Emergency Plan/Pick-Up: ....

Name: ....

Address: ....

Emergency/Hotline #: .... Website: ....

Emergency Plan/Pick-Up: ....

Name: ....

Address: ....

Emergency/Hotline #: .... Website: ....

Emergency Plan/Pick-Up: ....

Name: ....

Address: ....

Emergency/Hotline #: .... Website: ....

Emergency Plan/Pick-Up: ....

IN CASE OF EMERGENCY (ICE) CONTACT

Name: .... Mobile #: ....

Home #: .... Email: ....

Address: ....

OUT-OF-TOWN CONTACT

Name: .... Mobile #: ....

Home #: .... Email: ....

Address: ....

EMERGENCY MEETING PLACES

Indoor: ....

Instructions: ....

Neighborhood: ....

Instructions: ....

Out-of-Neighborhood: ....

Address: ....

Instructions: ....

Out-of-Town: ....

Address: ....

Instructions: ....

IMPORTANT NUMBERS OR INFORMATION

Police: .... Dial 911 or #: ....

Fire: .... Dial 911 or #: ....

Poison Control: .... #: ....

Doctor: .... #: ....

Doctor: .... #: ....

Pediatrician: .... #: ....

Dentist: .... #: ....

Medical Insurance: .... #: ....

Policy #: ....

Medical Insurance: .... #: ....

Policy #: ....

Hospital/Clinic: .... #: ....

Pharmacy: .... #: ....

Homeowner/Rental Insurance: .... #: ....

Policy #: ....

Flood Insurance: .... #: ....

Policy #: ....

Veterinarian: .... #: ....

Kennel: .... #: ....

Electric Company: .... #: ....

Gas Company: .... #: ....

Water Company: .... #: ....

Alternate/Accessible Transportation: .... #: ....

Other: ....

Other: ....

Step 4: Practice your plan with your family/household

HSEM

My Phone List

In an emergency always call: 9-1-1 (it's OK)

My home phone number is:

Mom: Cell: Work:

Dad: Cell: Work:

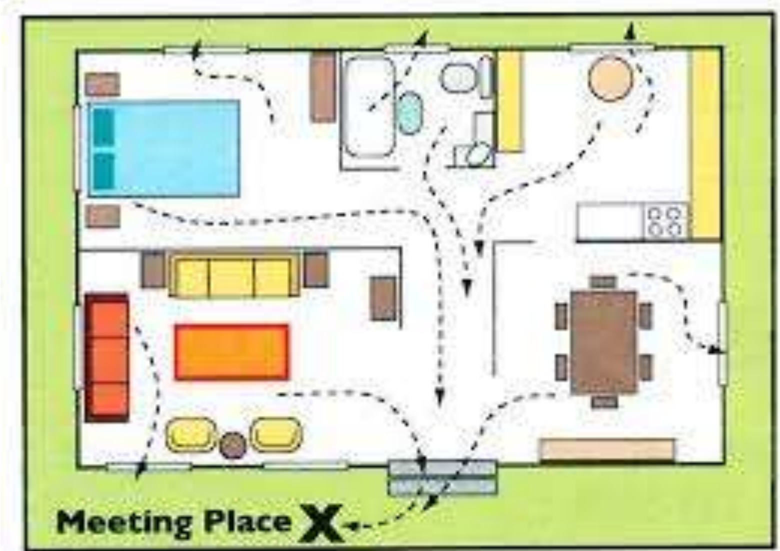
Grandma/Grandpa or Other Relative:

Or Other trusted person: (Somebody you know well)

Or Other trusted person: (Somebody you know well)

I live at:

Good Family Meeting Place:



I. Early Preparation for an Emergency or Disaster

1. Creating an emergency and disaster preparedness and response plan specifically for the board of pharmacy;
2. Working with the state legislature to enact emergency dispensing and other related provisions; "NABP Model Emergency and Disaster Preparedness and Response Plan."
3. Developing and maintaining a contact list of local/state government agencies and national pharmacy organizations;
4. Developing and maintaining a contact list of local/regional pharmaceutical manufacturers, wholesale drug distributors, and pharmacies that could donate and provide storage sites and transportation resources for critical drugs and supplies; and
5. Educate licensees on board efforts related to emergency or disaster planning

II. Immediate Response to an Emergency or Disaster

1. Activate the Board emergency or disaster response plan, place board of pharmacy members and staff on “standby;”

2. Initiate contact with local/state emergency management agencies, pharmaceutical manufacturers, wholesale drug distributors, pharmacies, and other entities if necessary;

3. Initiate contact with NABP regarding the potential need for emergency or disaster resource assistance;and

4. Alert licensees, national and local pharmacy associations, and the public.

III. Short-Term Response: The First 72 Hours Post-Disaster

1. Continue to employ the board's emergency or disaster response plan;
2. Initiate contacts with local/state government agencies to determine the public's medical and health needs;
3. Maintain communication with wholesale distributors and pharmaceutical manufacturers to ensure that adequate supplies of drugs and supplies are available and accessible;
4. Maintain use of NABP emergency and disaster resource assistance; and
5. Provide frequent information and updates, if possible, through various channels to licensees, the public, and other identified entities.

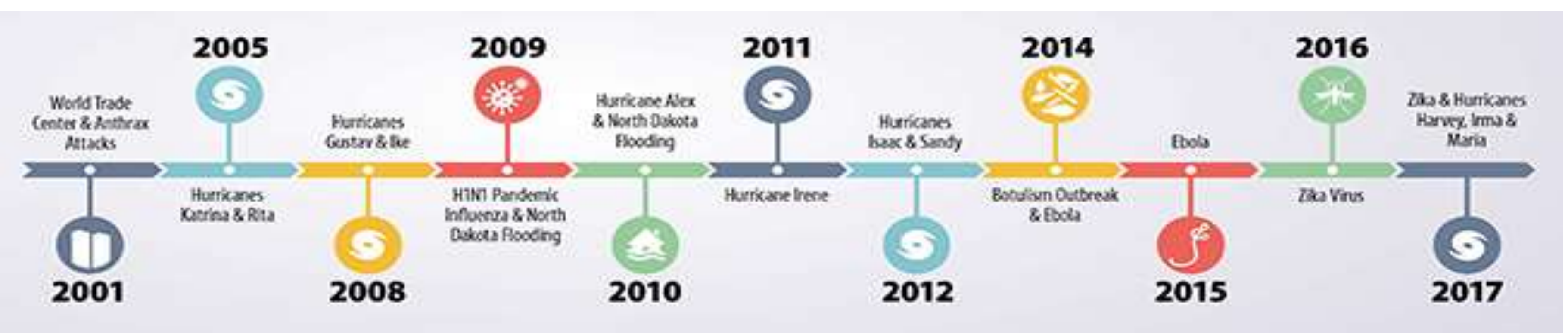
IV. Long-Term Response: 72 hours to 30 Days (Possibly Longer) Post Disaster

1. Work to restore and maintain critical board operations.
2. Sustain communications with important stakeholders, such as local/state emergency response agencies and pharmaceutical industry contacts;
3. Providing updates to the public and licensees.

Strategic National Stockpile (SNS)

*Created in 1999 to ensure the nation's readiness against potential agents of bioterrorism like botulism, anthrax, smallpox, plague, viral hemorrhagic fevers, and tularemia.

*Mission was to assemble large quantities of essential medical supplies that could be delivered to states and communities during an emergency within 12 hours of the federal decision to use the stockpile.



Duties of the SNS:

- Designs and delivers training and exercise support for public health and emergency staff and partners
- Maintains day-to-day situational awareness, ensuring the stockpile is ready to respond
- Manages the stockpile’s response activities during a public health emergency

Sustaining the Stockpile

Stockpile management includes:

- Overseeing the shelf life of medicines to ensure the stock is rotated and kept within U.S. Food and Drug Administration (FDA) potency shelf-life limits
- Conducting routine quality assurance on all products
- Performing annual inventory of all products
- Inspecting environmental conditions, security, and package maintenance
- Ensuring stockpile holdings are based on the latest scientific data and threat levels
- Ensuring the ability to transport items during a public health emergency

SNS Requests

How SNS assets are deployed

- Need for medicines and medical supplies exceeds county resources
- The county requests state assistance
- Need for medicines and medical supplies exceeds state resources
- The state requests federal assistance
- The Centers for Disease Control and Prevention (CDC) deploys SNS assets
- SNS augments local/state medical supplies

VOUCHERS FOR:

- Anthrax
- Influenza
- Plague
- Tularemia

https://www.dispenseassist.net

Dispense Assist Directives

- Per a directive from the Centers for Disease Control and Prevention large metropolitan regions have been tasked with delivering medication to the public within 48 hours after notification of a biological emergency event.

- Dispense Assist supports public health agencies with accomplishing this mission by providing an online screening tool that allows users to generate vouchers for medication.

Anthrax Medication Screening Form

Please complete the screening information below, then press the "Next" button at the bottom of the page for a printable voucher.

Personal Information

First Name: ______ **Last Name:** ______

Address: ______

Address2/Other: ______

City: ______ **State/Territory:** --Select One-- **Zip/Postal Code:** ______

Telephone: ( ) -

Email: ______

Date of Birth: mm / dd / yyyy

Weight (lbs): ______

Sex: ◯ Male ◯ Female

Medical Information

1.	Is this person allergic to Doxycycline, Tetracycline or any other 'cycline' drugs?	◯ Yes	◯ No
2.	Is this person allergic to Ciprofloxacin, Levaquin or any other 'floxacin' drug?	◯ Yes	◯ No
3.	Does this person have seizure disorder or epilepsy?	◯ Yes	◯ No
4.	Is this person currently taking Tizanidine (Zanaflex)?	◯ Yes	◯ No
5.	Does this person have difficulty swallowing pills?	◯ Yes	◯ No
6.	Does this person have renal (kidney) disease or Myasthenia Gravis?	◯ Yes	◯ No

I have been offered a copy of the Disease Information Sheet. By checking the 'I Agree' box, I consent to receive the antibiotic to be given to me or the person named above for whom I am authorized to sign.

☐ I Agree

After completing the screening information, press the "Next" button for a printable voucher.

Clear Form   Next

This voucher permits the individual named below to receive this medication. Print

BRING THIS VOUCHER WITH YOU

Dispense Assist

Post Exposure Prophylaxis Voucher

Medication: Either Ciprofloxacin or Doxycycline

Demographic Information

First Name:	Jane	Telephone:	(812) 555-5555
Last Name:	Doe	DOB:	01/24/2001
Address:	123 First Street	Age:	18
Address2:		Sex:	Female
City, St Zip:	Vincennes, IN 47591	Weight:	120
Email:	jdoe@gmail.com		

Health History Information

1. Is this person allergic to Doxycycline, Tetracycline or any other 'cycline' drug?	No
1a. Has person experienced respiratory (breathing) or cardiac (heart) arrest after taking this medication?	No
2. Is this person allergic to Ciprofloxacin or any other "floxacin" drug?	No
2a. Has person experienced respiratory (breathing) or cardiac (heart) arrest after taking this medication?	No
3. Does this person have seizure disorder or epilepsy?	No
4. Is this person taking Tizanidine (Zanaflex ©)?	No
5. Does this person have difficulty swallowing pills?	No
6. Does this person have renal (kidney) disease or Myasthenia Gravis?	No
7. Is this person pregnant?	No

I, the undersigned, certify that all of the above information is correct to the best of my knowledge. I hereby authorize th recipient of this document to share this information with public health entities at the local, state and federal level for purposes of ensuring medication efficacy and safety. I have been offered a copy of Notice of Information Practices.

Client Signature:______________________ Date Signed:__________

Point of Dispensing Use Only:

Medication Provided: ☐ Doxycycline ☐ Ciprofloxacin

Place Lot # Sticker Here

Dispensing Site Name:______________________

Dispenser Signature:______________ Date:________

Fact sheet: ***FDA EUA Either Ciprofloxacin or Doxycycline Drug Information Sheet***

Questions?