GREETER

JUST-IN-TIME TRAINING (JITT) FOR MEDICAL COUNTERMEASURE DISPENSING

Team Leader Packet

Cities Readiness Initiative

Clackamas • Clark • Columbia • Multnomah
Skamania • Washington • Yamhill

CONTENTS

GREETER

Just in Time Training (JITT) for Medical Countermeasure Operations
Greeter Team Leader Instructions

Materials needed:

Training Packet

- Greeter Job Action Sheet
- POD Overview
- Example blank Screening Form in English
- Example Dispense Assist Vouchers (C, D, CD, X)- Print one copy as example
- Pocket Communicator- print one copy as example

Greeter Supplies

- Pocket Communicator
- Blank Screening Forms in all available languages
- List of Interpretation Resources (phone numbers, on-site interpreters, etc)
- Pens
- Clipboards
- Document organizer for blank screening forms.

JITT Step 1: Hand out training packets to each person.

JITT Step 2: Review the POD Overview and Greeter Job Action sheet; If available, watch Greeter JITT video on CRI website (www.crinorthwest.org/pod-tools)

JITT Step 3: Discuss the role of the Greeter and answer questions.

JITT Step 3: Demonstrate how non-English speaking clients can point to their language on the "Pocket Communicator" in order determine what language resource a client would need.

Last Update: 11/16/19

GREETER

Job Action Sheet

Supplies Needed:

1. Pocket Communicator
2. Blank Screening Forms in all available languages
3. List of Interpretation Resources (phone numbers, on-site interpreters, etc.)
4. Pens
5. Clipboards
6. Document organizer for blank screening forms.

Educational Materials:

1. List of frequently asked questions

Signage

1. Greeter Station sign
2. “Do you have a Dispense Assist voucher?” sign
3. Directional arrow signs

REPORTS TO:

Greeting Team Lead: _____

Phone: _____

OBJECTIVE:

To welcome the client, provide information and direction, and determine if they need extra support in the POD via interpretation or other access and functional needs.

START OF SHIFT:

1. Sign in.
2. Obtain medication for yourself and your family.
3. Receive orientation and position training from Team Lead; If available, watch JITT Greeter video at www.crinorthwest.org/pod-tools.
4. Familiarize yourself with POD layout and flow.
5. Ensure your station is equipped with all necessary items.

DURING SHIFT:

1. Greet client as they enter the POD.
2. Determine if the client needs interpretation or additional needs and connect them to that resource, if available.
3. Ask if the client has Dispense Assist voucher(s).
4. If the client has Dispense Assist voucher(s):
    a. Send families with “X” voucher(s) to the form completion area to complete a handwritten screening form in preferred language.
    b. Send families with C, D, or C/D voucher(s) to the Dispensing station.
5. If the client does not have Dispense Assist voucher(s) direct them to the form completion area.
6. If your station has enough greeters, send extras to walk the waiting line to locate people with Dispense Assist vouchers, assist with using the Dispense Assist mobile app and direct them to proceed to Dispensing more quickly.
7. Take care of your own needs by taking breaks, eating and drinking plenty of water.

END OF SHIFT:

1. Train your replacement
2. Return any supplies issued to you (vest, badge, clipboard, etc.)
3. Sign out

Overview of POD Flow

Below are the primary stations in a POD and the tools, forms, documents needed in each station within the POD. Page two contains additional recommendations for improving POD flow and functionality.

Step 1

Greeting:
(1) Provide Screening Form if they do not have Dispense Assist (DA) vouchers or have a voucher with a "X".

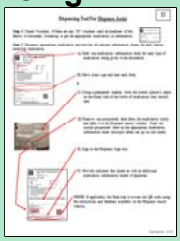
(2) Send to Dispensing if they have DA Vouchers with D,C, or C/D.

Form Area:
(1) Assist clients in filling out their forms, as needed.

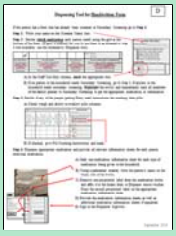
(2) Direct to Dispensing.

Step 2

Dispensing:



Voucher



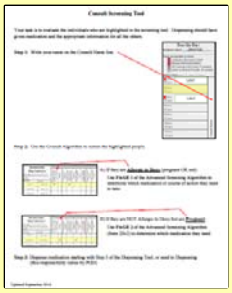
Forms

(1) Decide which medication to give.
(2) Identify more complex individuals and highlight.

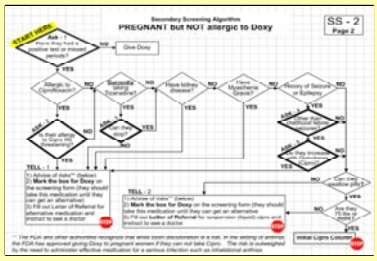
For all individuals not highlighted:
(3) Decide if pill crushing instructions are needed.
(4) Attach labels from medication bottle to Screening Form (or DA voucher) and info sheet.
(5) Write client name on medicine bottle.
(6) Give appropriate medications and Information Sheet.

If needed:
(7) Send any people with highlights on their form to Consult (keep families together).

Consult:
Screen the highlighted people



Consult Tool



Screening Algorithm

(1) Decide which medication to give or action to take.
(2) If needed, give Letter of Referral.

(3) Decide if pill-crushing instructions are needed.
(4) Attach labels from medication bottle to the Screening Form and Info Sheet.
(5) Write client name on medicine bottle .
(6) Give appropriate medications and Information Sheet.

EXIT

EXIT

Federally Approved Emergency Use Information sheets:

Cipro

Doxy

Pill Crushing

Updated 9/2019

POD Flow and Functionality Best Practices

Outside the POD

- Make use of time in line by distributing disease/medication information to those waiting.
- Ensure there are bathrooms and/or portable toilets inside and outside the POD.
- If resources or time are limited, establish a cutoff point for the line.
- Provide sufficient shelter from weather for those waiting outdoors.
- Provide chairs and ensure access for those with mobility needs.

Greeting

- Keep families together throughout the entire process.
- Speed up the line by fast-tracking those with Dispense Assist (DA) vouchers straight to dispensing.

Forms Area

- Ensure staff are available to help people fill out forms - including in-person or phone interpreters, as needed - check for completion, and send them Dispensing when complete.
- Utilize a numbering system to ensure people are served in an orderly manner and the Dispensing area remains clear of long lines.

Dispensing

- If space and staffing allow, create separate Dispensing stations for those with handwritten forms and those with Dispense Assist vouchers.

Consult

- Ensure there are dedicated Dispensing staff to work at the Consult station. This ensures clients do not have to move backward in line to receive their medication.

POD Floor Plan and Staffing

- Draw up your floor plan and then determine where staff are needed. Design your POD flow so that lines never cross each other.
- Always post staffing at decision points in the line and flow of the POD (flow monitors).
- Ensure there is appropriate and highly visible signage throughout the POD.
- Plan for staff breaks away from crowds and restrict food consumption to break areas.
- Plan ahead for clients with access and functional needs.
- Empower staff to adjust POD flow and fix issues as they arise.

Updated 9/2019

ANTIBIOTIC MEDICATION SCREENING FORM

I certify that all the information below is correct to the best of my knowledge. I authorize the recipient of this document to share this information with public health entities at local, state and federal levels for purposes of ensuring medication efficacy and safety.

Phone: ____________ Address: ______________ ZIP Code: _______ Age: __ Signature: _______________

INSTRUCTIONS: READ CAREFULLY

Step 1: Print the names of everyone you are picking up medications for today, starting with yourself.

Step 2. Check (✓) in column ONLY if person has the condition(s) listed.

FIRST NAME	LAST NAME	*Allergic to doxycycline, tetracycline, or other "cycline"[1] drugs?	Pregnant?	*Allergic to ciprofloxacin, Levaquin, or other "floxacin"[2] drugs?	Currently taking Tizanidine (Zanaflex)?	Has Myasthenia Gravis?	Currently has renal (kidney) disease?	Ever had SEIZURES or EPILEPSY?	Weighs less than 76 pounds?	Unable to swallow pills?	STAFF USE ONLY
											☐ Doxy ☐ Cipro ATTACH LABEL WITH LOT #
											☐ Doxy ☐ Cipro ATTACH LABEL WITH LOT #
											☐ Doxy ☐ Cipro ATTACH LABEL WITH LOT #
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											☐ Doxy ☐ Cipro ATTACH LABEL WITH LOT #
											☐ Doxy ☐ Cipro ATTACH LABEL WITH LOT #

Consult Name:

STAFF USE ONLY

Dispenser Name:____________________

Check all provided to client:

- ☐ Antibiotic Information Sheet
- ☐ Disease Information Sheet
- ☐ Pill Crushing Instructions (if needed)
- ☐ Letter of Referral (Consult only)

Today's Date:____ / ____ / _____

STAFF USE ONLY

Dispensing Guide and Formula

Allergic to doxycycline / Pregnant	Other 5 columns	Weight / Swallow	Result
No checkmarks	+ No checkmarks	+ No checkmarks	= *Dispense* ***doxycycline or ciprofloxacin***
No checkmarks	+ Checkmarks	+ No checkmarks	= *Dispense* ***doxycycline***
No checkmarks	+ With or without checkmarks	+ Checkmarks	= *Dispense* ***doxy w/ pill crushing instructions***
Checkmarks	+ No checkmarks	+ No checkmarks	= *Dispense* ***ciprofloxacin***
Checkmarks	+ Checkmarks (in any of these 7 columns)		= *Send to Consult* ***highlight row***

In this case, Allergic means this person experienced respiratory (breathing) or cardiac (heart) arrest after taking this medication

1 **Tetracycline Drug List:** demeclocycline (Declomycin); doxycycline (Adoxa, Alodox, Atridox, Avidoxy, Doryx, Doxy, Monodox, Morgidox, Ocudox, Oracea, Oraxyl, Periostat, Vibramycin); minocycline (Arestin, Dynacin, Minocin, Solodyn, Ximino)

2 **Quinolone Drug List:** ciprofloxacin (Cipro); gatifloxacin (Tequin); levofloxacin (Levaquin); moxifloxacin (Avelox); nadifloxacin (Acuatim); norfloxacin (Noroxin); ofloxacin (Floxin)

Last Update: 7-30-19

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

BRING THIS VOUCHER WITH YOU

Dispense Assist
Post Exposure Prophylaxis Voucher

Medication: Ciprofloxacin

Demographic Information

First Name:	**Greta**	**Telephone:**	**(354) 569-8564**
Last Name:	**Greterson**	**DOB:**	**05/16/1985**
Address:	**1234 Testy Test Road**	**Age:**	**34**
Address2:		**Sex:**	**Female**
City, St Zip:	**Portland, OR 97851**	**Weight:**	**120**
Email:	**greta@greatgreta.com**		

Health History Information

1. Is this person allergic to Doxycycline, Tetracycline or any other 'cycline' drug?	**Yes**
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?	**Yes**

I, the undersigned, certify that all of the above information is correct to the best of my knowledge. I hereby authorize the 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 Ciprofloxacin Drug Information Sheet***

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

BRING THIS VOUCHER WITH YOU

Dispense Assist
Post Exposure Prophylaxis Voucher

Medication: Doxycycline

Demographic Information

First Name:	**TEST**	**Telephone:**	**(503) 123-4567**
Last Name:	**PERSON**	**DOB:**	**12/07/1975**
Address:	**1234 TEST ROAD**	**Age:**	**43**
Address2:		**Sex:**	**Female**
City, St Zip:	**PORTLAND, OR 97124**	**Weight:**	**150**
Email:	**test@test.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?	**Yes**
2a. Has person experienced respiratory (breathing) or cardiac (heart) arrest after taking this medication?	**Yes**
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**

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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 Doxycycline Drug Information Sheet***

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:	**John**	**Telephone:**	**(503) 998-8545**
Last Name:	**Johnson**	**DOB:**	**06/20/1979**
Address:	**1245 Tester Road**	**Age:**	**40**
Address2:		**Sex:**	**Male**
City, St Zip:	**Portland, OR 97124**	**Weight:**	**220**
Email:	**john@johnson.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**

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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***

Print

DO NOT DISPENSE MEDICATION!

Thank you for submitting your medication form. Unfortunately, your answers indicate that you are unable to receive any of the medications that are currently available. Please contact your health care provider or your local health department for additional information.

Demographic Information

First Name:	Sally	Telephone:	(123) 456-7891
Last Name:	Smith	DOB:	5/14/1950
Address:	1234 Testing Road	Age:	69
Address2:		Sex:	Female
City, St Zip:	Portland, OR 97123	Weight:	200
Email:	sally@test.com		

Health History Information

1. Is this person allergic to Doxycycline, Tetracycline or any other 'cycline' drug?	Yes
1a. Has person experienced respiratory (breathing) or cardiac (heart) arrest after taking this medication?	Yes
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?	Yes
3. Does this person have seizure disorder or epilepsy?	No
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Client Signature:_____ Date Signed:_____

POCKET COMMUNICATOR

I SPEAK...

ASL American Sign Language	Русском Russian
اللغة العربية Arabic	Soomaali Somali
普通话 Chinese	español Spanish
日本語 Japanese	Tagalog Tagalog
ភាសាខ្មែរ Khmer	Українською Ukrainian
한국어 Korean	Tiếng Việt Vietnamese
Română Romanian	

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