Memorandum of Agreement (MOA)
Regarding Mass Prophylaxis Dispensing
CLOSED Point of Dispensing (POD)

This Memorandum of Agreement is entered into this the ___ day of ___________, 2007 between the ____ (Provider) and the CITY Government, more specifically HEALTH DEPARTMENT NAME/ACRONYM.

Definitions:

1. HEALTH DEPARTMENT NAME/ACRONYM
2. SNS: Strategic National Stockpile
3. POD: Point of Dispensing
4. Provider: Business/Organization willing to become a CLOSED POD

Recitals

WHEREAS, the Centers for Disease Control and Prevention (CDC) has established the Cities Readiness Initiative (CRI) program to assist certain Metropolitan Statistical Areas (MSA) in the event of a catastrophic biological incident; and

WHEREAS, the CDC, through the STATE HEALTH DEPARTMENT (MDHSS OR KDHE), will provide the Strategic National Stockpile (SNS), which includes medications and medical supplies, to HEALTH DEPARTMENT NAME/ACRONYM for the Kansas City MSA; and

WHEREAS, the HEALTH DEPARTMENT NAME/ACRONYM approves the transfer of a pre-determined quantity of the aforementioned medication to (provider name): and

WHEREAS, the HEALTH DEPARTMENT NAME/ACRONYM wishes to collaborate with (provider name) to enhance its ability to respond to a catastrophic biological incident or other communicable threat of epidemic proportion.

NOW THEREFORE, in consideration of the foregoing, the parties hereto agree as follows:

The Provider Agrees:

a. To request medications according to the number of employees and identified household family members (if applicable).

b. To assume responsibility of dispensing medications (mass prophylaxis) to those individuals identified above by the Provider's trained staff, at a site chosen by the Provider and with no liability assumed by the HEALTH DEPARTMENT NAME/ACRONYM.

c. To utilize pharmaceuticals in accordance with the policies and procedures outlined in the HEALTH DEPARTMENT NAME/ACRONYM Public Health Emergency Response Plan and the Provider's own Mass Prophylaxis Dispensing Plan (on file with the HEALTH DEPARTMENT NAME/ACRONYM).

d. To dispense medications per established medical protocols/algorithms (provided by HEALTH DEPARTMENT NAME/ACRONYM at time of the event) under the supervision of licensed medical personnel.

e. To provide any updates of the Provider's Mass Prophylaxis Dispensing Plan to the HEALTH DEPARTMENT NAME/ACRONYM.

f. To provide training and education to all Provider's staff that will be utilized in Mass Prophylaxis Dispensing Operations in regards to specifics of the Mass Prophylaxis Dispensing Plan provided by the Provider.

g. To identify employees by jurisdiction of residence and provide that information to HEALTH DEPARTMENT NAME/ACRONYM.

h. To not charge individuals for medications or administration of that have been provided through this agreement, except as permitted by the STATE OF (MISSOURI/KANSAS) or by CDC.

i. To participate in any HEALTH DEPARTMENT NAME/ACRONYM-sponsored dispensing training/education opportunities.

j. To provide emergency point of contact information to ensure timely notification of the Provider in the event of a public health emergency.

k. To dispense medications and/or supplies in accordance with the guidance provided by HEALTH DEPARTMENT NAME/ACRONYM.

l. To maintain accurate records (inventory) of medications dispensed and then provide those to HEALTH DEPARTMENT NAME/ACRONYM in a timely manner.

m. To secure any unused medications until a time HEALTH DEPARTMENT NAME/ACRONYM can make arrangements for retrieval.

n. To compile and file an after-action report with the HEALTH DEPARTMENT NAME/ACRONYM, identifying shortfalls and accomplishments of the operation.

The HEALTH DEPARTMENT NAME/ACRONYM Agrees:

a. To provide Mass Prophylaxis Dispensing specific training/education opportunities to identified staff of the Provider.

b. To provide pre-event planning and technical assistance, including but not limited to supply lists, POD layouts, fact sheets, dispensing algorithms, etc.

c. To, conditionally, ensure delivery/availability of the appropriate amount of medications in a reasonable, timely manner

d. To provide coordination as outlined in the HEALTH DEPARTMENT NAME/ACRONYM Emergency Plan to the Provider to the best of their ability.

e. To provide the Provider with proper standing orders and medical protocols regarding Dispensing activities including but not limited to, dosing, follow-up procedures and releasable information regarding the public health emergency situation.

f. To provide the Provider with consultation and assistance as needed and available for the given public health emergency.

g. To make arrangements to collect any unused medications as well as copies of all medical documentation.

h. To provide after-action consultation to the Provider.

It Is Mutually Agreed That:

a. The confidentiality of patients and patient information will be maintained as written and enforced by the Health Insurance Portability and Accountability Act (HIPAA).

b. This Memorandum can be extended by two-year intervals with agreement of both parties.

c. This Memorandum can be amended by mutual agreement of both parties at any time and may be terminated by either party upon 60 days notice in writing to the other party.

d. This Memorandum will not supersede any laws, rules or polices of either party.

e. This Memorandum will go into effect only at the request and direction of the HEALTH DEPARTMENT NAME/ACRONYM.

f. The Provider would be considered a CLOSED POD in that it would not Dispense Medications to the “general public” but to identified staff, family members, patients, contacts, and specific groups outlined in the Provider’s Mass Prophylaxis Dispensing Plan and the HEALTH DEPARTMENT NAME/ACRONYM Emergency Plan.

g. The Provider will follow the dispensing directives of the HEALTH DEPARTMENT NAME/ACRONYM during Mass Dispensing Operations.

h. It is understood that the Provider's participation is completely voluntary and may not be available/utilized at the time of the event. If so, the Provider would not be considered a CLOSED POD and their staff and/or specific groups would be required to attend a Public/OPEN POD operated by HEALTH DEPARTMENT NAME/ACRONYM and not receive any preferential treatment.

SIGNATURES

My signature indicates agreement with the above stated agreements and conditions:

Director of the HEALTH DEPARTMENT NAME/ACRONYM	Date
(Provider Representative)	Date
(Provider Representative)	Date
City Manager	Date