NACCHO
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2017 Model Practices

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Model Practice Title

Please provide the name or title of your practice: *

New York City Department of Health and Mental Hygiene, Office of Emergency Preparedness and Response

Practice Categories

Model and Promising Practices are stored in an online searchable database. Applications may align with more than one practice category. Please select all the practice areas that apply.: *

- [x] Access to Care
- [ ] Advocacy and Policy Making
- [ ] Animal Control
- [x] Coalitions and Partnerships
- [ ] Communications/Public Relations
- [ ] Community Involvement
- [ ] Cultural Competence
- [x] Emergency Preparedness
- [ ] Environmental Health
- [ ] Food Safety
- [ ] Global Climate Change
- [ ] Health Equity
- [ ] HIV/STI
- [ ] Immunization
- [ ] Infectious Disease
- [ ] Informatics
- [ ] Information Technology
- [ ] Injury and Violence Prevention
- [ ] Marketing and Promotion
- [ ] Maternal-Child and Adolescent Health
- [x] Organizational Practices
- [ ] Other Infrastructure and Systems
- [x] Organizational Practices
- [x] Primary Care
- [ ] Quality Improvement
- [ ] Research and Evaluation
- [ ] Tobacco
- [ ] Vector Control
- [ ] Water Quality
- [ ] Workforce
- [ ] Conference Theme: Bridging Clinical Medicine and Population Health

Other::

Is this practice evidence based, if so please explain. :

Winnable Battles

To keep pace with emerging public health challenges and to address the leading causes of death and disability, CDC initiated an effort called Winnable Battles to achieve measurable impact quickly.Winnable Battles are public health priorities with large-scale impact on health and known effective strategies to address them. Does this practice address any CDC's seven Winnable Battles? If so, please choose from the following:: *

- ☐ Food Safety
- ☐ HIV in the U.S.
- ☐ Nutrition, Physical Activity, and Obesity
- ☐ Tobacco
- ☐ Healthcare-associated Infections
- ☐ Motor Vehicle Injuries
- ☐ Teen Pregnancy
- ☑ None

Overview: Provide a brief summary of the practice in this section (750 Word Maximum)

Your summary must address all the questions below:

- Brief description of LHD- location, demographics of population served in your community
- Describe public health issue
- Goals and objectives of the proposed practice
- How was the practice implemented/activities
- Results/Outcomes (list process milestones and intended/actual outcomes and impacts.
  - Were all of the objectives met?
  - What specific factors led to the success of this practice?
- Public Health impact of practice
- Website for your program, or LHD.

750 Word Maximum

Please use this portion to respond to the questions in the overview section. : *

The NYC Department of Health and Mental Hygiene (DOHMH) is one of the world’s oldest and largest public health agencies. The Health

Department has over 5500 employees and serves over 8 million ethnically and socio-economically diverse people living in the five boroughs of New York City. With an ambitious mission to protect and promote the health of all New Yorkers, DOHMH is frequently a leader in innovative policy and system and environmental approaches to public health. In addition, the agency is committed to developing bold strategies and programs that promote health, prevent disease, and improve access to quality healthcare. The agency is strategically organized into divisions, bureaus, offices and work units, all of which work together cohesively to provide essential public health services. The agency is led by Commissioner of Health, Dr. Mary Bassett. She is supported by Deputy, Associate and Assistant Commissioners who oversee 13 divisions and over 50 bureaus and offices. Public health programs and activities managed by the agency are diverse and many. Programs and activities include: disease surveillance; outbreak investigation; registration and analysis of all vital (birth and death) events; clinics (STD, TB and Immunization); veterinary and pest control services; early intervention services; tobacco cessation; school health; HIV prevention and control; collection, analysis and dissemination of public health data; restaurant and daycare inspections; chronic disease prevention and management; health education; laboratory testing services; coordination of medical, dental, and mental healthcare in NYC jails; supporting the adoption and use of prevention-oriented electronic health records among primary care providers in NYC's under-served communities; policy development; and internships and residencies for future public health professionals.The DOHMH serves all of NYC, which has 8.3 million residents; this is more than twice that of the nation's next most populous city. NYC is racially and ethnically diverse: 24% black, 27% Hispanic, 35% white and 12% Asian. Thirty seven percent of the population is foreign born and 20% of foreign born residents have immigrated in the last ten years. Over 1.2 million New Yorkers (more than 15%) live in the City's highest need areas (areas with the lowest health indicators, and highest mortality); these include East and Central Harlem, a large area of the South Bronx, and neighborhoods in North and Central Brooklyn. In these areas, poverty rates are 70% to 100% higher than the citywide poverty rate of 21%, and over 95% of residents are nonwhite. Blacks account for 25% of the city's population overall, but 49% in high need areas. Hispanics are 42% of residents in high need communities, compared with 27% citywide. With some areas of great wealth, NYC also has some areas of widespread poverty: 21% of New Yorkers live in poverty, compared to 12% nationwide. While the median annual household income is $38,293, the income range is wide, making NYC home to considerable economic disparity. About one third of the population receives some form of public assistance and just over one quarter of the population is college educated. Notable for the Associate's work is the size and complexity of NYC's healthcare system. In the five boroughs of NYC, there are 55 acute care hospitals, 450 ambulatory and primary care centers, 178 nursing homes and 74 adult care facilities. Describe public health issue. New York City Department of Health and Mental Hygiene (NYC DOHMH), Hospital Preparedness Program (HPP) has operated as a distinct program since 2002. Over the last fourteen years, DOHMH's HPP has engaged its health care partners in actively assessing their preparedness for all-hazard approach, and it has funded these entities to work toward implementing a program that translates the Assistant Secretary of Preparedness and Response (ASPR), National Hospital Preparedness program priorities for national preparedness to local level action The HPP continues to prioritize preparedness planning in the primary care sector, as key to supporting the hospital response to any large-scale public health emergency. However, based on literature review conducted, there is not a comprehensive emergency preparedness program dedicated to primary care centers so that primary care sites are able to function post disaster, providing continuity of care to the populations they serve as well as those displaced by the disaster. Based on previous disasters, we know that primary care centers play a vital role within the communities. This was evident from Hurricane Katrina in 2005 whereby, primary care services were provided by community health centers to treat patients with chronic illnesses in order to ensure continuity of care and offer mental health counseling to those who were distraught. As well as during the H1N1 pandemic influenza outbreak, primary care sites were used to decreased the case burden on emergency departments and provided care to underserved populations by offering a delivery infrastructure for vaccines and trained nurses to treat patients.2, 3, The goals and objectives of the PCEPN model are: 1) to increase the ability of NYC's primary care community to prepare for, respond to, and recover from a disaster, and 2) to ensure that primary care is represented in citywide emergency planning and response. Because the primary care sector is a vital component of healthcare system preparedness in New York City, in 2009, the NYC Department of Health and Mental Hygiene (DOHMH) Office of Emergency Preparedness and Response partnered with the Community Health Care Association of New York State (CHCANYS) and the Primary Care Development Corporation (PCDC) to form the Primary Care Emergency Preparedness Network (PCEPN) model. CHCANYS and PCDC signed a mutual aid agreement to form the PCEPN, which is supported by the Hospital Preparedness Program (HPP) cooperative agreement. The PCEPN was implemented via a healthcare system coalition model. PCEPN is coalition of primary care providers and centers. The structure of the PCEPN model requires that CHCANYS and PCDC jointly develop concept of operations and activation manuals to guide the ongoing development and operationalization of PCEPN. PCEPN is staffed by certified emergency managers from both organizations to complete programmatic deliverables that are aligned with the Health Resources and Services Administration (HRSA) emergency management expectations and HPP capabilities. CHCANYS and PCDC collaborate with NYC DOHMH to produce program deliverables (e.g. plan development, training, exercises, and risk assessments) within each fiscal year. DOHMH reviews and vets all materials created and shared with the primary care sector. The contract renewal is dependent upon performance and the availability of HPP funding. Upon completion of these program deliverables, reimbursement is provided. Funding is not provided directly to the individual primary care sites. Results/Outcomes (list process milestones and intended/actual outcomes and impacts) The objectives of the PCEPN model were met, and the following outcomes were achieved: • Established the organization and mission of PCEPN • Created PCEPN Standard Operating Procedures • Created HSEEP compliant Multi-Year Training/Exercise Plan • Developed a tiered EP system for PCC participation in PCEPN • Developed and refined the PCEPN EP Toolkit (i.e. EOP, COOP) • Conducted communications drills via the web-based situational awareness/notification system • Developed PCEPN website to share PCC specific EP materials • Established PCEPN Advisory Board • Conducted community preparedness initiatives (linking PCCs with community partners) • Conducted HVA for the primary care sector and "Readiness" project to assess level of readiness for the primary care sector • Created Hazard Specific Plans for the primary care sector (i.e., Infectious Disease Outbreak and Coastal Storm Plans) • Conducted mystery patient drills to test primary care centers' screening and isolation protocols for communicable disease/emerging infectious diseases The success of the practice is due to the collaboration and partnership between the local health department, and non-profit primary care associations and organizations. PCEPN model improves linkages and collaboration among public health, emergency management, and local primary care associations. The partnership between public health and primary care is essential for effectively responding to and recovering from public health threats and reduce adverse health outcomes that impact communities post-disasters. www.pcepn.org

Responsiveness and Innovation

A Model Practice must be responsive to a particular local public health problem or concern. An innovative practice must be (1) **new to the field of public health (and not just new to your health department)** OR **(2) a creative use of an existing tool or practice**, including but not limited to use of an Advanced Practice Centers (APC) development tool, The Guide to Community Preventive Services, Healthy People 2020 (HP 2020), Mobilizing for Action through Planning and Partnerships (MAPP), Protocol for Assessing Community Excellence in Environmental Health (PACE EH). Examples of an inventive use of an existing tool or practice are: tailoring to meet the needs of a specific population, adapting from a different discipline, or improving the content.

- Statement of the problem/public health issue
- What target population is affected by problem (please include relevant demographics)
    - What is the target population size?
    - What percentage did you reach?
- What has been done in the past to address the problem?
- Why is the current/proposed practice better?
- Is current practice innovative? How so/explain?
    - Is it new to the field of public health
      OR
    - Is it a creative use of existing tool or practice:
      What tool or practice did you use in an original way to create your practice? (e.g., APC development tool, The Guide to Community Preventive Services, HP 2020, MAPP, PACE EH, a tool from NACCHO's Toolbox etc.)
- Is the current practice evidence-based? If yes, provide references (Examples of evidence-based guidelines include the Guide to Community Preventive Services, MMWR Recommendations and Reports, National Guideline Clearinghouses, and the USPSTF Recommendations.)

2000 Word Maximum

Please state the Responsiveness and Innovation of your practice (2000 Word Maximum) : *

Problem Statement: Lack of integration of the primary care sector in citywide planning for disasters and public health emergencies; as well as a comprehensive emergency management program dedicated to the primary care sector. So they can provide continuity of care for the medically underserved populations that they serve. The target population is primary care centers/health centers. There are ~ 42 health center grantees in NYC operating more than 300 sites.(1) Of these more than 300 sites, about 100 provide primary care services to the general public. The others serve special populations (e.g., homeless), are at special locations (e.g., schools) or provide limited services (e.g., dental only). Of sites serving the general public, the Bronx has the most sites (37) and Staten Island the fewest (2). In 2011, health centers served 800,000 New Yorkers citywide – 10% penetration of the NYC population, ranging from 25% in the Bronx to 4% in both Queens and Staten Island.4 Health center penetration of NYC's low-income population was 26% but this too varied by borough. The Bronx had the highest health center penetration of low-income population by borough (48%) and Queens the lowest (12%). Federally funded health centers must provide comprehensive primary care services either directly or by referral. On average, NYC community health centers directly provided medical services to 90% of their patients, dental services to 20% of their patients, mental health services to 8% of their patients, and substance abuse treatment to less than 1% of their patients. Community health centers predominantly serve patients who have Medicaid (or other need-based public insurance) or who are uninsured. In NYC, 53% of health center patients had Medicaid and 23% were uninsured.2 Statewide, 51% of health center patients had Medicaid and 25% were uninsured, while nationwide 42% of health center patients had Medicaid and 36% were uninsured. Although half of NYC health center patients had Medicaid, the proportion of publicly insured patients varied by grantee, ranging from 29% to 80%. The proportion of uninsured patients also varied by grantee, ranging from 1% to 61%. In 2011, both uninsured adults and adults in low-income households were more likely than insured adults and adults in higher-income(d) households, respectively, to report not having a regular care provider or not getting needed care. As federally funded health centers must accept patients regardless of insurance status or ability to pay, health centers can provide access to health care for the underserved. Health center grantees must serve high-need populations or underserved areas but health center sites are not necessarily located in areas with high proportions of uninsured adults or low-income residents. Many patients use community health center sites outside their neighborhood(e). Health center penetration varies across NYC neighborhoods. Some NYC neighborhoods have high proportions of uninsured adults or low-income population yet have low health center penetration (Tria, M.E. Epi Data Brief, October 2013; https://datawarehouse.hrsa.gov/). New York City (NYC) is home to ~42 Federally Qualified Health Centers (FQHC) primary care networks (PCN) that represent 372 individual sites (including mobile and school-based sites). Of those, 35 FQHC PCNs (representing 330 individual sites or ~89% of the total NYC FQHCs) are currently members of PCEPN. In addition to FQHCs, PCEPN's membership is also comprised of 10 non-FQHC PCNs (representing ~119 individual sites), bringing the total PCEPN membership to 45 distinct PCNs with ~449 individual PCCs. What has been done in the past to address the problem? The Primary Care Emergency Preparedness Network (PCEPN) is a functional coalition whose members work closely to support primary care emergency preparedness and response in New York City (NYC). It was formed in 2009 by the alliance of two smaller network organizations, each with intent to support medically underserved communities through better delivery of primary care: the Primary Care Development Corporation (PCDC) and the Community Health Care Association of New York State (CHCANYS). PCDC is a nonprofit organization, dedicated to expanding and transforming primary care in underserved communities, in order to improve health outcomes, lower health costs and reduce disparities, by way of its programs in capital investment, performance improvement, as well as policy and advocacy for community-based healthcare facilities. CHCANYS is a group that serves as the voice

of community health centers as leaders in primary health care provision for New York State, in order to ensure that all New Yorkers, including those who are medically underserved, have continuous access to high quality community-based health care services, including a primary care home. In accordance with their missions, both organizations had been supporting primary care centers in the development of emergency management programs, but were doing so through separate funds from the NYC Department of Health and Mental Hygiene (DOHMH). After working cooperatively in 2009 on Pandemic Influenza H1N1 response efforts, however, they decided to align and streamline their efforts specific to emergency management in NYC through the formation of the PCEPN. By July 2010, PCEPN began receiving its own federal health care preparedness grants through DOHMH. NYC DOHMH prior to the inception of the PCEPN model, funded primary care associations and organizations separately to carry various activities, to address the gaps identified in emergency preparedness in NYC. The challenges with this approach primary care sector 1) information sharing were not streamlined and 2) emergency preparedness documentations/materials were not standardized. Why is current/proposed practice better? Is current practice innovative? How so/explain? The current practice is innovative, in that The Primary Care Emergency Preparedness Network (PCEPN) is a subject matter expertise (SME) coalition led by Community Health Care Association of New York State (CHCANYS), which is the Primary Care Association of New York State. PCEPN supports primary care emergency preparedness and response activities in New York City (NYC). With representatives from federally qualified health centers, hospital based sites, and specialty care centers. PCEPN's main focus is to increase the level of emergency preparedness capacity across the primary care sector in NYC through: advocacy for primary care emergency management activities, coordination of information among stakeholders, providing technical assistance to build/maintain primary care EM capacity, and integrating primary care into NYC emergency planning. The benefits of PCEPN includes, representative at the New York's Emergency Support Function (ESF) 8, Health and Medical Desk as the body linking primary care sector, to local health department and external first responder agencies during a response for disasters and/or public health emergencies. Additional, the PCEPN model: Enhanced preparedness to respond to and recover from emergencies through participation in training, exercises, and other technical assistance offered by PCEPN to its members; Facilitate of assessments to determine how prepared sites are; and provide technical assistance to improve emergency preparedness and business continuity planning; The PCEPN model applied the Mobilizing for Action through Planning and Partnership (MAPP). The structure of the PCEPN model requires that CHCANYS and PCDC jointly develop concept of operations and activation manuals to guide the ongoing development and operationalization of PCEPN. CHCANYS is the primary care association of New York State and its purpose is to ensure that all New Yorkers, including those who are medically underserved, have continuous access to high quality community-based health care services including a primary care home. CHCANYS represents more than 60 federally qualified health centers (FQHC) that operate more than 600 individual sites in every region of New York State, serving nearly 2 million patients annually. The Primary Care Development Corporation (PCDC) is a nonprofit organization dedicated to expanding and transforming primary care in underserved communities to improve health outcomes, lower health costs and reduce disparities8. These two organizations signed a mutual aid agreement to form the Primary Care Emergency Preparedness Network (PCEPN) model. PCEPN is staffed by certified emergency managers from both organizations to complete programmatic deliverables that are aligned with the Health Resources and Services Administration (HRSA) emergency management expectations and HPP capabilities. CHCANYS and PCDC collaborate with NYC DOHMH to produce program deliverables (e.g. plan development, training, exercises, and risk assessments) within each fiscal year. DOHMH reviews and vets all materials created and shared with the primary care sector. The contract renewal is dependent upon performance and the availability of HPP funding. Upon completion of these program deliverables, reimbursement is provided. Funding is not provided directly to the individual primary care sites. The primary care sites are recruited to participate in the PCEPN model by CHCANYS and PCDC. The selection criteria for sites to participate in the PCEPN model is that they must provide comprehensive primary health care services and also be considered as a: a) Primary Care Center (PCC) - a single location/facility where primary care services are delivered; b) Primary Care Network (PCN) - an organization that may encompass multiple service sites, including PCCs; 10 c) Federally Qualified Health Centers (FQHCs) - includes all organizations receiving grants under Health Center Program statutes under Section 330 of the Public Health Service Act; 11 and/or d) FQHC Look-Alike – an organization that provides primary care services, but does not carry an FQHC designation. Primary care sites volunteer to become a member of PCEPN; there are no mandates or regulatory rules that bind sites to participate. PCEPN membership comprises only primary care sites within the five boroughs of New York City due to the cooperative agreement requirements. Using its membership as proxy for the primary care sector, PCEPN's mission is twofold. It is to: 1) Increase the ability of NYC's primary care community to prepare for, respond to, and recover from a disaster, and 2) to ensure that primary care is represented in citywide planning and response.13 Primary care sites who participate in PCEPN receive technical assistance with emergency management protocol and policies development, risk assessments, trainings, and disaster preparedness drills and exercises. More importantly, PCEPN serves as an essential proxy for surveillance of infectious diseases for the community. Is the current practice evidence-based? If yes, provide references (Examples of evidence-based guidelines include the Guide to Community Preventive Services, MMWR Recommendations and Reports, National Guideline Clearinghouses, and the USPSTF Recommendations.) The Institute of Medicine (IOM) defines Primary Care as, "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."1 This "community" aspect of primary care delivery underscores why primary care is so critical to emergency preparedness. All emergencies are locally experiences, and all response and recovery efforts usually begin within an affected community. Its primary care providers build ongoing relationships with their patients, who often consider them as trusted sources of information, especially during emergencies. Their patients will expect them to know how to respond in these periods, and will look to them for the provision of everything from reassurance to care. In addition, through these patient relationships, primary care providers generally know their communities well, and so could identify vulnerable individuals who may need extra care and/or social services following a disaster. Even outside of these emergency periods, primary care practitioners can play a large role in improving community outcomes from an emergency. According to the National Health Security Strategy, "health is a key component of overall community resilience"; resilience, in turn, is an important component in recovery from disaster. Indeed, general good health and well-managed chronic conditions before a disaster leads to enhanced resilience in the post-disaster setting. Therefore, through effective treatment for acute illnesses and minor traumas, and management of chronic illness year round, primary care providers can improve the health of their patients, and therein enhance their community's resiliency in the wake of disasters. The importance of emergency management planning and programs for primary care is bolstered by the various requirements set forth by

regulatory agencies, including New York State Department of Health (NYS DOH; Article 28 of NYS Public Health Law);8 the federal Health Resources and Services Administration (HRSA; Public Information Notice (pin) 2007-15—applies to FQHCs and LALs);9 and the federal Centers for Medicaid Services (CMS; proposed rule under review to apply to all Medicaid and Medicare participating providers and suppliers). The Joint Commission, an independent non-profit organization that accredits and certifies health care facilities, also sets forth emergency management standards. To meet both community needs and regulatory requirements, it is critical that primary care providers have robust emergency management programs. Based on literature review conducted, very little information was provided on an emergency management program developed and geared toward the primary care sector. However, research as shown Primary care faces many challenges in preparing for emergencies such as financial limitations, degree of clinical capacity barriers and challenges that patients may face (e.g. lack of health insurance, illiteracy, etc.), and finally, the lack of integration or connectedness to public health.1,2,3 Additionally, primary care can provide increased medical surge capacity by building their internal infrastructure and implementing training programs.4 Primary care safety nets such as federally qualified health centers play a vital role in pandemic influenza response by decreasing case burden on emergency rooms via triage as well as providing care to typically underserved populations.2 This highlights the importance of emergency management training in primary care centers to provide and/or enhance surge capacity in the community in which they serve. More research is needed in this area on emergency preparedness for the primary care sector to prepare for, respond to and recovery from disasters. References: 1. Rust G, Melbourne M, Truman BI, Daniels E, Fry-Johnson Y, Curtin T. Role of the primary care safety net in pandemic influenza. Am J Public Health. 2009; 99 (Suppl 2): S316-S323. 2. Ablah E, Tinius AM, Horn L, Williams C, Gebbie KM. Community health centers and emergency preparedness: an assessment of competencies and training needs. J Community Health. 2008; 33(4): 241-47. 3. Ablah E, Konda KS, Konda K, Melbourne M, Ingoglia JN, Gebbie KM. Emergency preparedness training and response among community health centers and local health departments: results from a multi-state survey. J Community Health. 2010; 35(3): 285-293. 4. Sharaf E. Planning for disasters in primary care. Bahrain Med Bull. 2009; 31(1): 1-5.

LHD and Community Collaboration

The LHD should have a role in the practice's development and/or implementation. Additionally, the practice should demonstrate broad-based involvement and participation of community partners (e.g., government, local residents, business, healthcare, and academia). If the practice is internal to the LHD, it should demonstrate cooperation and participation within the agency (i.e., other LHD staff) and other outside entities, if relevant. An effective implementation strategy includes outlined, actionable steps that are taken to complete the goals and objectives and put the practice into action within the community.

- Goal(s) and objectives of practice
- What did you do to achieve the goals and objectives?
    - Steps taken to implement the program
- Any criteria for who was selected to receive the practice (if applicable)?
- What was the timeframe for the practice
- Were other stakeholders involved? What was their role in the planning and implementation process?
    - What does the LHD do to foster collaboration with community stakeholders? Describe the relationship(s) and how it furthers the practice goal(s)
- Any start up or in-kind costs and funding services associated with this practice? Please provide actual data, if possible. Otherwise, provide an estimate of start-up costs/ budget breakdown.

5000 words maximum

Enter the LHD and Community Collaboration related to your practice (5000 words maximum): *

The goal and objective of the Primary Care Emergency Preparedness Network is to strengthen and build emergency preparedness capacity among primary care sites in NYC to prepare for, respond to and recover from disasters and/or public health emergencies, PCEPN achieves its mission through: • Recruitment and on-going engagement of primary care centers • Situational awareness • Facility-level assessments • Education and Training • Plan development and exercising • Community Linkages The the goals and objectives were achieved by? • Established the organization and mission of PCEPN • Created PCEPN Standard Operating Procedures • Created HSEEP compliant Multi-Year Training/Exercise Plan • Developed a tiered EP system for PCC participation in PCEPN, o Tier I: sites designated as Tier I were those sites that had a comprehensive Emergency Management Plan, Functional Business Continuity Planning, and Integrated with community and/or citywide plans o Tier II: sites designated as Tier II were those sites that had a functioning Emergency Management Plan (EMP) and basic Business Continuity Planning o Tier III: sites designated as Tier III were those sites with only a basic Emergency Operations Plan (EOP) • Developed and refined the PCEPN EP Toolkit (i.e. EOP, COOP) • Conducted communications drills via the web-based situational awareness/notification system • Developed PCEPN website to share PCC specific EP materials • Established PCEPN Advisory Board • Conducted community preparedness initiatives (linking PCCs with community partners) • Conducted Hazard Vulnerability Assessment (HVA) for the primary care sector and "Readiness" project to assess level of readiness for the primary care sector • Created Hazard Specific Plans for the primary care sector (i.e., Infectious Disease Outbreak and Coastal Storm Plans) • Conducted mystery patient drills to test primary care centers' screening and isolation protocols for communicable disease/emerging infectious diseases • Conducted Respiratory Protection Workshops and Respiratory Fit Testing Trainings to providers Steps taken to implement the program: • Convene a meeting with key stakeholders that included representatives from New York City's Emergency Management (NYC EM), Primary Care Association – Community Health Care Association of New York State (CHCANYS), non-profit primary care organization – Primary Care Development Corporation; which became a workgroup to establish the program. • Community Health Care Association of New York State and the Primary Care Development Corporation had internal meetings, draft mutual aid agreement, which was signed by the Chief Executive Officer (CE0) of both organizations. • Based on

Assistant Secretary of Preparedness and Response, Health and Human Services (HHS) Healthcare Capabilities, the NYC Department of Health and Mental Hygiene; contract with CHCANYS and PCDC as PCEPN, to provide Emergency Management programs to the primary care sector that aligns with HPP Capabilities as well as HRSA Emergency Management Expectations. The contract is renewable dependent on performance and availability of funding. • The workgroup then drafted an Emergency Support Function 8 (ESF-8), Health and Medical Emergency Operations Representation Proposal, to have a seat at ESF-8, to represent the primary care sector. The purpose of the seat was to provide a formalized and efficient communications link between NYC emergency planners, local health department and primary care providers during public health emergencies. The inclusion of primary care in NYC's emergency planning and response will help close the gap that currently exist between the City and primary health care providers and the population they serve rely heavily upon for quality of care not only during normal state but as well as during/post disasters. The success of this project creates standardized protocols for activation, enabling NYC's emergency planners and local health department to receive timely information from primary care providers and increase situational awareness in the primary health care. This proposal of PCEPN being represented at ESF 8, Health and Medical Desk, would address the gap of no formalized, sustainable means of communication between NYC's emergency planners and primary care. • Established the roles and responsibilities of the PCEPN model as an ESF-8 partners included: o PCEPN staff members that works for both CHCANYS and PCDC will be identified to act as liaisons to NYC Emergency Management o Provide NYC EM with up-to-date 24 hour contact information o Review and update PCEPN emergency plans o Represent primary care in citywide drills, training sessions and exercises, as well as encourage individual primary care sites to participate in these activities o Disseminate relevant information to primary care providers as requested by NYC Department of Health and Mental Hygiene and NYC Emergency Management o Attend necessary NYC Emergency Management training (e.g. Emergency Operations Centers, Citywide Incident Management Systems (CIMS), Incident Command System (ICS) o Participate in ESF -8 Incident Action Planning activities, as needed o Provide situational briefings to the ESF-8, Health and Medical Coordinator, as requested (if activated) o Submit resource request to the ESF-8, Health and Medical Coordinator, as needed (if activated) • Established the PCEPN Advisory Board that is representative of the five boroughs of New York City, and the types of services provided by the center. The roles and responsibilities of the board members are, the members: o Serve a twelve-month term as an Advisory Board member (sign a commitment letter of participation) (members are rotated annually) o Participate in at least four meetings and/or conference calls o Advocate for primary care emergency preparedness o Promote inclusion of primary care sector in planning and response activities citywide o Advise on relevant issues facing the primary care sector o Engage in the development of program activities e.g. annual emergency seminar, educational concepts and needs/gaps assessment tool o Provide guidance on strategies to increase sites participation and engagement o Market emergency management tools and resources created by PCEPN, such as, infection control plan template, business continuity plan template, respiratory protection program plan templates • Established the recruitment strategy, to invite primary care centers to participate in the program activities PCEPN will provide to members. The selection criteria for sites to participate in the PCEPN model is that they must provide comprehensive primary health care services and also be considered as a: a) Primary Care Center (PCC) - a single location/facility where primary care services are delivered; b) Primary Care Network (PCN) - an organization that may encompass multiple service sites, including PCCs; 10 c) Federally Qualified Health Centers (FQHCs) - includes all organizations receiving grants under Health Center Program statutes under Section 330 of the Public Health Service Act; 11 and/or d) FQHC Look-Alike – an organization that provides primary care services, but does not carry an FQHC designation. 10,11,12 Primary care sites volunteer to become a member of PCEPN; there are no mandates or regulatory rules that bind sites to participate. The timeframe of the program is over a 5-year cooperative agreement grant. The program receives funding from ASPR HHS, National Hospital Preparedness Program – fife-year cooperative agreement grant. The program was established in 2009; and with funding still exit today. Were other stakeholders involved? What was their role in the planning and implementation process? The stakeholders involved were NYC Emergency Management – obtaining buy-in that PCEPN will have a seat/representation at ESF-8, providing PCEPN staff with training so they can effectively staff the seat at ESF-8, Primary Care organizations and Associations i.e. Community Health Care Association of New York State – willingness to reach out to primary care providers, to assess their baseline level of emergency preparedness and work with the local health department to create emergency management activities to address the gaps identified.. Overall these partners provided support for and implementation of the project. What does the LHD do to foster collaboration with community stakeholders? Describe the relationship(s) and how it furthers the practice goal(s)? The New York City Department of Health and Mental Hygiene, has established the NYC Healthcare Coalition, Leadership Council; on a quarterly basis leadership council meetings are conducted to share best/promising practices and to support and foster collaboration. Additionally, the NYC Department of Health and Mental Hygiene, has continue to foster collaboration by working closely during disasters with the PCEPN and integrating it within its Incident Command Structure. In the New York City Department of Health and Mental Hygiene; Incident Command Structure, there is a branch that is called the Healthcare Systems Support Branch, which liaise with PCEPN during a response. For example, during the Ebola Incident; New York City Department of Health and Mental Hygiene worked collaboratively with PCEPN, to schedule Ebola Preparedness Site Visits to primary care centers, to assess needs and offer guidance on screening and isolation procedures. As a result of this, the Mystery Patient Drill project has been initiative. Whereby, unannounced drill is conducted using the NYC Medical Reserve Corp volunteers as the "mystery patient" to test sites screening and isolation protocols for communicable disease preparedness. Start-up Cost – Budget – Deliverable Based Contract Deliverables - Estimated Cost 1a.Identify Planning team; submit point of contact information to NYC DOHMH. Meeting dates, agencies, sign-in sheets, and notes from meetings = $1,800.00 2a. Organizational Document delineating the roles of the organizations = $5,000.00 2b. Signed Memorandum of Understanding between the parties involved clearly documenting roles and responsibilities = $5,000.00 3a. Conduct a Hazard Vulnerability Analysis (HVA) for the primary care sector identify gaps and perceived risks = $5,000.00 3b. CHCANYS will develop internal organizational protocols for EM Program staff = $5,000.00 3c. PCDC will develop internal organizational protocols for EM program staff = $5,000.00 3d. Activation Manual – submit an activation manual with roles and responsibilities, and activation triggers for various emergency scenarios =$20,000.00 4a. PCEPN will submit meeting notes, agenda, sign-in sheet and a report (now formalized entity – CHCANYS +PCDC)=$15,000.00 5a.Conduct Homeland Security Exercise and Evaluation Program (HSEEP) Training and Exercise Planning Workshop (TEPW) that will focus on the development of a Multi-Year Training and Exercise Plan for PCEPN 5b.HSEEP Multi-Year Training and Exercise Draft Plan =$10,000.00 5c.HSEEP Plan Final Draft=$5,000.00 6a.Contact Maintenance Procedures=$8,0000.00 6b.Spreadsheet containing the primary care sites, location and point of contract recruited into the program =$3,000.00 Overall

Total=$100,000.00

Evaluation

Evaluation assesses the value of the practice and the potential worth it has to other LHDs and the populations they serve. It is also an effective means to assess the credibility of the practice. Evaluation helps public health practice maintain standards and improve practice. Two types of evaluation are **process** and **outcome**. Process evaluation assesses the effectiveness of the steps taken to achieve the desired practice outcomes. Outcome evaluation summarizes the results of the practice efforts. Results may be long-term, such as an improvement in health status, or short-term, such as an improvement in knowledge/awareness, a policy change, an increase in numbers reached, etc. Results may be quantitative (empirical data such as percentages or numerical counts) and/or qualitative (e.g., focus group results, in-depth interviews, or anecdotal evidence).

- What did you find out? To what extent were your objectives achieved? Please re-state your objectives.
- Did you evaluate your practice?
    - List any primary data sources, who collected the data, and how (if applicable)
    - List any secondary data sources used (if applicable)
    - List performance measures used. Include process and outcome measures as appropriate.
    - Describe how results were analyzed
    - Were any modifications made to the practice as a result of the data findings?

2000 Words Maximum

Please enter the evaluation results of your practice (2000 Words Maximum): *

What did you find out? To what extent were your objectives achieved? Please re-state your objectives. The Primary Care Emergency Preparedness Network (PCEPN) model, a coalition of primary care providers and centers, is collaboration between government and primary care associations that offers technical assistance to primary care sites to better prepare for, respond to, and recover from disasters. Our objective was to determine whether primary care sites in New York City that participated in PCEPN were better prepared for public health emergencies than non-participating sites. Did you evaluate your practice? To evaluate the impact of the PCEPN model on the primary care sector's emergency preparedness in NYC, we designed a survey for primary care sites. Primary care sites eligible for inclusion were based on PCEPN membership recruitment criteria as well as New York State Department of Health (NYS DOH) Article XXVIII Diagnostic and Treatment Centers – "certain ambulatory care facilities under Section 330 of the Public Health Services Act…Section 330 grantees, federally funded health centers; federally qualified health centers community health centers, or health centers. They are community-based, public or private, non-profit health centers that provide comprehensive primary care services to medically underserved areas or populations. These centers cannot refuse patients on the basis of insurance status or ability to pay." 11,14 All primary care sites were located within one of NYC's five boroughs: Bronx, Brooklyn, Manhattan, Queens, or Staten Island. For purposes of this evaluation: PCEPN sites" were facilities/centers that were members between 2009 and 2014. "Non-PCEPN sites" were defined as facilities/centers that were never members of PCEPN. PCEPN sites were identified from the PCEPN membership roster. Non-PCEPN primary care sites were identified through the New York State Department of Health's (NYS DOH) Health Commerce System. The survey was administered to only sites in the five boroughs of New York City. The questionnaire was developed to align with the HRSA Emergency Management Expectations for Health Centers as well as HHS HPP emergency management capabilities for healthcare systems.8,9 The questionnaire included 77 items that addressed several domains: Facility/center demographic information, emergency management plans, continuity of operations, drills and exercises, and community linkages. The study was reviewed and exempted by the NYC DOHMH Institutional Review Board (IRB Protocol #15-046). Sites participating in PCEPN were compared against sites that had never participated. Prior to fielding the survey, the questionnaire was piloted at two primary care sites. These sites were selected based on their active participation in PCEPN initiatives. The survey tool was revised based on feedback received. The survey was fielded from July 7 through July 30, 2015. Primary care sites were sent the invitation via email to complete the 77-item online questionnaire at SurveyMonkey®15 on July 7 and two reminders were sent on July 9 and July 20. On July 23, sites that had not yet responded were cold called by DOHMH staff. Through CHCANYS, PCEPN emailed the invitation to participate in the survey to 297 primary care sites, which represented 18 primary care networks (PCNs) that were PCEPN members. PCN leads were asked to obtain facility level information and forward the survey to the appropriate site-level leads. Of the 18 PCNs contacted, 14 confirmed receipt of the invitation. The New York State Department of Health's Integrated Health Alert Network System invited 362 non-PCEPN sites located within NYC's five boroughs to participate in the survey. Of these 362 sites, 74 confirmed receipt of the survey invitation. Data was collected from respondents via SurveyMonkey®15 and compiled in Microsoft Excel. NYC DOHMH collected the data, and data analysis was provided by Centers for Disease Control and Prevention. We learned, that PCEPN sites were more likely to have completed a hazard vulnerability analysis (OR: 2.99; 95% CI: 1.40, 6.37), identified essential services for continuity of operations (OR: 2.33; 95% CI: 1.04, 5.24), have memoranda of understanding (MOUs) with external partners (OR: 2.48; 95% CI: 1.19, 5.19), and completed point-of-dispensing training (OR: 6.87; 95% CI: 2.39, 19.79). The top 3 preparedness gaps for both PCEPN members and nonmembers were improved communication, resource availability, and train-the-trainer programs. Results suggest PCEPN sites had better planning, communication, financial operation stability, and linkages than non-participating sites.

Sustainability

Sustainability is determined by the availability of adequate resources. In addition, the practice should be designed so that the stakeholders are invested in its maintenance and to ensure it is sustained after initial development (*NACCHO acknowledges that fiscal challenges may*

limit the feasibility of a practice's continuation.)

- Lessons learned in relation to practice
- Lessons learned in relation to partner collaboration (if applicable)
- Did you do a cost/benefit analysis? If so, describe.
- Is there sufficient stakeholder commitment to sustain the practice?
    - Describe sustainability plans

1500 Words Maximum

Please enter the sustainability of your practice (2000 Words Maximum): *

Lessons learned in relation to practice • Reluctance of sites to participate since there is no regulatory mandates • Reluctance of site to participate since there is no financial incentives • Primary care centers – shortage and depth of staff; cannot commit dedicated staff to emergency preparedness and planning; as well as high turnover of staff members Lessons learned in relation to partner collaboration (if applicable) • Partners competing priorities, to advocate and represent their members on other policy issues, outside of emergency preparedness and response. • Competing priorities will implementing Federal and State programs, such as, the Affordable Care Act; and Delivery System Reform Incentive Program (DSRIP Did you do a cost/benefit analysis? If so, describe. No. Is there sufficient stakeholder commitment to sustain the practice? Describe sustainability plans – PCEPN drafted an Action and Sustainability Plan in 2015, which outlines action items to sustain the program: 1. Recruitment, retention and reengagement strategy: via partners such as, NYC Medical Reserve Corps (MRC) and county medical societies, to recruit medical groups for membership and/or participation in activities, or just to make them aware of PCEPN resources. Cross-recruitment of providers in partnership with the Primary Care Information Project (PCIP), coordinated by NYC DOHMH, will also be explored. Visibility of PCEPN programs and advocacy efforts will be increased through participation in health care coalition meetings and ongoing participation in ESF-8 planning meetings. In order to reengage and retain current members, PCEPN will again focus on BCP and efforts to increase executive-level interest in preparedness. In addition, PCEPN expects to support member engagement with enhanced communications through a new website with greater analytics capability, new mailing list functionality through Constant Contact; and expansion of the HC Standard communication platform for situational awareness between PCEPN and its members. Finally, to maintain members' desire to remain not only as PCEPN members (retention), but as active PCEPN members (reengagement), ongoing and more targeted core activities—training and exercises—will also be used. PCEPN intends to track members' participation in all activities provided. 2.Maintenance and Enhancement of Member Preparedness: PCEPN will use the experiences of the last 5 years (which included real-world responses for Hurricane Irene and SuperStorm Sandy; HVAs; and evaluation and gap assessment through the Readiness Project) to move forward with a more clearly-defined, evidence-based approach that will maintain and enhance member preparedness. By conducting the following: a. Re-define roles for primary care. In order for primary care providers to become ready and willing partners in preparedness, they must first understand where they fit into the larger NYC preparedness and response landscape. Together with ESF-8 partners such as DOHMH, NYC EM, and the New York State Department of Health (NYS DOH), we will determine which roles primary care can play in emergency response based on different planning scenarios. b. Determine capabilities to support roles. After determining roles by scenario, capabilities required to successfully carry out the responsibilities of those roles must be defined and communicated to primary care providers. c. Create an assessment protocol and tools to measure capabilities and assess gaps. Assessments must be capability-based as much as is possible to be meaningful and to allow for accurate understanding of preparedness levels and gaps. Ways to increase the objectivity of the assessment will be considered, taking into account the limited time members have to dedicate to emergency management activities. Tier definitions will also be evaluated and updated as necessary. d. Create meaningful content/offer TA to members to maintain and improve preparedness. PCEPN will inform program development through role and capability expectations, taken together with needs identified during assessments, and gaps identified in PCEPN work to date. See item 4 below for details on projects planned. e. Reassess member readiness status annually and share results with stakeholders.

Additional Information

How did you hear about the Model Practices Program:: *

- ☐ I am a previous Model Practices applicant
- ☐ At a Conference
- ☑ NACCHO Website
- ☐ Public Health Dispatch
- ☐ Colleague in my LHD
- ☐ Model Practices brochure
- ☐ NACCHO Exhibit Booth
- ☐ NACCHO Connect
- ☐ Colleague from another public health agency
- ☐ E-Mail from NACCHO
- ☐ NACCHO Exchange