PCEPN

Primary Care Emergency Preparedness Network

PCEPN Action and Sustainability Plan

June 2015

Version 2.1

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PCEPN
Primary Care Emergency Preparedness Network

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Primary Care Emergency Preparedness Network

I. Introduction

The Primary Care Emergency Preparedness Network (PCEPN) is a functional coalition of primary care providers within New York City (NYC). It was formed in 2009 and is a cooperative partnership between the Primary Care Development Corporation (PCDC) and the Community Health Care Association of New York State (CHCANYS). CHCANYS' 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. To do this, CHCANYS serves as the voice of community health centers as leading providers of primary health care in New York State. PCDC is a nonprofit organization dedicated to expanding and transforming primary care in underserved communities to improve health outcomes, lower health costs and reduce disparities through its capital investment, performance improvement, and policy and advocacy programs. Both organizations had been receiving funding separately from the NYC Department of Health and Mental Hygiene (DOHMH)and providing support to primary care centers to develop emergency management programs prior to working cooperatively on Pandemic Influenza H1N1 response efforts in 2009. PCEPN was formed to align and streamline those efforts. PCEPN as an entity began receiving federal health care preparedness grant funding through DOHMH in July 2010.

PCEPN's mission is to increase the ability of the NYC primary care community (using its members as proxy for the larger sector) to prepare for, respond to, and recover from a disaster, and to ensure that primary care is represented in citywide planning and response. To that end, PCEPN provides technical assistance (TA) to support providers' emergency management (EM) programs, including emergency plan templates, training, and exercise development and facilitation. Through its efforts, PCEPN works to ensure that primary care is incorporated into citywide emergency planning, and that the sector is represented within Emergency Support Function (ESF) 8 (Public Health and Medical) when it is activated. PCEPN provides a link between its members, the larger NYC health care community, and local government agencies to enhance health system preparedness within NYC. This Action and Sustainability Plan describes the strategic vision, and means to achieve that vision, for increasing PCEPN's membership and maintaining and enhancing members' preparedness during Budget Periods (BPs) 4 and 5 of the current funding cycle. Although it provides specific information for only 2 budget periods, it is the foundation upon which PCEPN will continue to provide the TA and advocacy necessary to ensure that primary care is recognized as a critical partner in NYC emergency response plans, and that PCEPN members are willing and prepared to fulfill their roles during an emergency in NYC. This Action and Sustainability Plan is based on level funding for BP4 and BP5. Changes to this plan will be made to accommodate funding changes and/or revised planning assumptions.

II. The Primary Care Sector and Emergency Preparedness

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] The "community" aspect of the definition is critical with regard to emergency preparedness. All emergencies are local, and all response and recovery usually begins within an affected community. Primary care providers build ongoing relationships with their patients, and personal physicians are often considered trusted sources of information, especially during emergencies.[2,3,4,5] Their patients will expect them to know how to respond, and will look to them for care, even if they were not directly impacted by the emergency and are simply looking for reassurance amidst uncertainty. Primary care providers also enhance a community's resiliency, which is key to its recovery after a disaster. According to the National Health Security Strategy, "health is a key component of overall community resilience."[6] Through effective management of chronic illness, and treatment for acute illnesses and minor traumas, primary care providers improve the health of their patients. General good health and well-managed chronic conditions before a disaster leads to enhanced resilience in the post-disaster setting.[7] In addition, 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. Resiliency is also supported by providers ensuring that they have business continuity and other emergency response plans that help them to get back to normal operations as quickly as possible after an emergency. 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).[10] The Joint Commission, an independent non-profit organization that accredits and certifies health care facilities, also sets forth emergency management standards.[11] To meet both community needs and regulatory requirements, it is critical that primary care providers have robust emergency management programs.

A universal definition of which entities comprise the primary care sector is subject to interpretation. For the purposes of this Action and Sustainability Plan, PCEPN defines the NYC primary care sector to include: Primary Care Networks (PCNs) that operate Primary Care Centers (PCCs); stand-alone ambulatory care practices owned by hospitals, community-based boards of directors, or nonprofit entities (under New York State Public Health Law Title 10, Article 28); for-profit healthcare practices; and other non-hospital points of entry into the healthcare system. Current members are hospital-affiliated and non-affiliated primary care centers, Federally Qualified Health Centers (FQHCs) and Look-Alikes (LALs). Though not previously included in this definition because they have not fit the traditional primary care model for care coordination, there are over 100 urgent care centers within NYC, most offering at least some services that overlap with primary care.[12] Therefore, PCEPN plans to explore the expansion of this working definition to include urgent care centers in NYC.

III. Overview of Current PCEPN Membership and Requirements

PCEPN currently has 43 member networks comprised of 297 sites located across the 5 boroughs of NYC. See Appendix A for a complete list of PCEPN members as of May 2015, including information on FQHC designations. Table 1 shows the number of PCEPN member sites by borough as of May 2015.

Borough	Number of PCEPN member sites
Brooklyn	82
Bronx	105
Queens	47
Manhattan	58
Staten Island	5
Total	297

Table 1. PCEPN Member Sites by Borough as of May 2015

Upon joining PCEPN, members undergo a baseline assessment to evaluate members' readiness based on scores across 52 data elements in 10 emergency management-related areas. Assessments have been completed for 42 of the 43 member networks to date. Results of those assessments were used to place members into 1 of 3 tiers. See Table 2 for tier definitions and Figure 1 for a breakdown of PCEPN member networks by tier level. For additional information on baseline assessment methods, please refer to reports submitted to DOHMH during BP1 and BP2 of the current funding cycle.

Tier 1	**Score of 80-100%**	➢ Comprehensive emergency management program established. ➢ Annual emergency management training and drills, emergency operations plan is updated through after action reports & integrated into primary care network quality management process. ➢ Primary care network has elements covering a business continuity plan. ➢ Primary care network has elements of Community Integration: Emergency response role/responsibilities of primary care network defined within community.
Tier 2	**Score of 65-79%**	➢ Emergency management plan established. ➢ Annual emergency management training and drills, emergency operations plan is updated through after action reports & integrated into primary care network quality management process.
Tier 3	**Score of 0-64%**	➢ Primary care network has minimal elements of an emergency management program.

Table 2: PCEPN Member Tier Descriptions as of May 2015

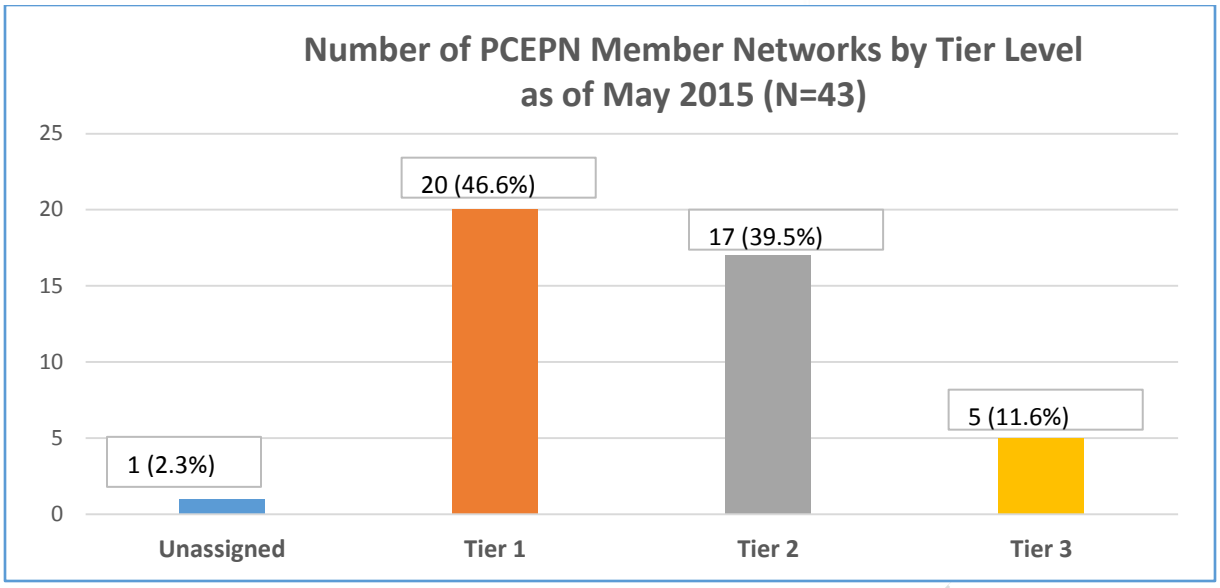

Figure 1: PCEPN Member Networks by Tier Level as of May 2015

All current PCEPN member networks have signed commitment letters stating their intent to be part of PCEPN. Members are also expected to participate in at least 2 activities per grant year and to provide current and accurate contact information to maintain their membership status. Notably, during BP3 82% of members participated in at least 2 activities to date (the goal was reengagement of 80% of the 40 members PCEPN had at the beginning of BP3).

IV. PCEPN Key Accomplishments 2009-2015

Since its formation in 2009, PCEPN has: provided training and TA for its members; performed hazard vulnerability analyses for the NYC primary care sector; assessed the primary care sector's readiness using its members as proxy; secured a seat to represent its members in the citywide Emergency Operations Center as part of Emergency Support Function (ESF) 8; supported its members through Hurricane Irene and SuperStorm Sandy; and grown to include 297 member sites across the 5 boroughs of NYC, among many other accomplishments. In short, PCEPN has assisted primary care centers across NYC in making significant improvements in emergency preparedness and response planning. Table 3 provides a more detailed listing of key accomplishments from 2009-2015. See Appendix B for a complete list of accomplishments.

2009-2010	➢ Conceptual development of PCEPN through PCDC and CHCANYS H1N1 response coordination
2010-2011	➢ Defined PCEPN's mission and organization ➢ Conducted a Hazard Vulnerability Analysis (HVA) for the NYC primary care sector ➢ Updated emergency activation manual and communication protocols ➢ Secured a seat for primary care during ESF-8 activations ➢ Conducted training and exercise workshops and developed HSEEP-compliant multi-year training and exercise plan
2011-2012	➢ Developed tier system based on capabilities and level of participation ➢ Conducted baseline assessments and assigned members to tiers ➢ Established PCEPN Advisory Board ➢ Developed a PCEPN emergency preparedness toolkit, including Business Continuity Plan (BCP) templates ➢ Launched PCEPN website ➢ Created Tier 1 site-specific community partner and resource catalog ➢ Established PCEPN in citywide ESF-8 planning meetings ➢ Supported PCCs during Hurricane Irene
2012-2013	➢ Conducted first round of community integration workshops ➢ Worked with PCEPN Advisory Board to develop 5-year strategic plan ➢ Supported PCCs during SuperStorm Sandy ➢ Created Tier-specific course catalog for members ➢ Assisted 10 PCCs affected by SuperStorm Sandy with AARs ➢ Incorporated lessons learned from Superstorm Sandy AAR into EOC activations manual
2013-2014	➢ Integrated 7 PCNs into PCEPN, hospitals, and/or DOHMH exercises ➢ Developed summary of preparedness gaps, best practices, and recommendations utilizing members' baseline assessment data ➢ Trained members on drill design and execution and assisted 7 network members with an exercise to address Superstorm Sandy response gaps ➢ Updated course catalog based on gaps identified in the 2012 baseline assessments; Superstorm Sandy AARs; and 2010 HVA ➢ Conducted 2nd Community Integration and Resiliency workshop
2014-2015	➢ Evaluated current state of readiness of the primary care sector in NYC ➢ Conducted a new primary care sector HVA ➢ Held a full-day Primary Care Sector Emergency Management Conference for members and stakeholders ➢ Created Coastal Storm and Infectious Disease Outbreak plan templates ➢ Conducted tabletop exercise with 11 network members ➢ Conducted 61 Ebola Site Visits to review plans and offer TA ➢ Conducted 21 Mystery Patient Drills to test knowledge and utilization of screening and isolation protocols for infectious diseases ➢ Created an Action and Sustainability Plan to define how PCEPN will expand its membership and maintain preparedness among its members

Table 3. PCEPN Key Accomplishments by Year—2009-2015

V. Membership Expansion and Ongoing Engagement

PCEPN has consistently expanded its membership each year, and expects to do so during BP4 and BP5. By adding members, PCEPN expands its reach, which contributes to increased levels of preparedness among primary care sites across NYC. Table 4 shows the growth in the number of member networks and sites for Budget Period (BP) 1, BP2, and BP3 of the current funding cycle.

Budget Period Ending June 30	Number of Networks	Number of Sites
2012-2013 (BP1)	31	124
2013-2014 (BP2)	40	220
2014-2015 (BP3)	43	297

Table 4. Number of PCEPN Member Networks and Sites by Year-Current Funding Cycle

To expand membership during BP4 and BP5, PCEPN will do the following:

1. *Identify potential members for direct recruitment based on targeted criteria to meet identified gaps*

Primary care is an ever-changing sector and often includes complex organizational structures which make it challenging to define targets for expanding membership. To optimize funding during BP4, PCEPN will focus on recruiting up to 5 primary care networks during BP4 that are not currently members, with a focus on FQHCs and LALs, as this segment of the primary care sector is clearly defined. Target PCNs will be identified by Quarter 1 (Q1) of BP4. It will also use BP4 to further explore the value and feasibility of additional targets for recruitment during BP5 and beyond, including urgent care centers and large group primary care practices, particularly those located in areas of NYC not currently represented by PCEPN members.

2. *Clearly define the benefits of PCEPN membership and communicate those benefits to potential members*

The benefits of PCEPN membership include:

- Enhanced preparedness to respond to and recover from emergencies through participation in training, exercises, and other TA offered by PCEPN to its members;
- Advocacy/representation among ESF-8 partners in NYC, including NYC DOHMH, NYC Emergency Management (EM), and others;
- Facilitation of assessments to determine how prepared sites are;

- Technical assistance to improve emergency preparedness and business continuity planning;
- Greater understanding of the role of primary care in emergency response;
- Opportunities for enhanced community integration through coalitions; and
- Ability to network and share best practices with other members.

PCEPN has requested member feedback on their perceived benefits of membership during its most recent communications drill, and will utilize the feedback received to further refine the benefits listing above by Q1 of BP4.

3. *Implement recruitment activities to add and reengage members*

PCEPN will utilize several strategies to reach potential new members, as well as to reengage existing members on an ongoing basis during BP4 and BP5. Most significantly, PCEPN's recruitment strategy and messaging moving forward will be based on a resiliency model. The critical need for business continuity planning (BCP) and PCEPN's ability to provide TA to assist them with BCP will be the focus of all recruitment communications. Executive level staff, as well as designated EM staff at potential member sites will be targeted for recruitment messaging. In addition, the benefits noted above will be clearly stated on an updated PCEPN website anticipated to launch in late 2015, as well as in communications and recruitment materials sent to potential members in future. The updated website will contain links to planning guidance and templates from PCEPN and other trusted sources, as well as reports completed by PCEPN, such as the Readiness Project Report (2015) and HVA (2015). PCEPN will also work with partners, such as the 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 to expand reach. 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.

The focus on BCP and efforts to increase executive-level interest in preparedness will be used to reengage current members. In addition, 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 are expected to support member reengagement. Ongoing core activities—training and exercises—will also be used to maintain members' interest in PCEPN participation. Table 5 provides a summary of recruitment and reengagement activities.

Action Item	Methods	Anticipated Timing
Identify potential members for direct recruitment based on targeted criteria to meet identified gaps	Determine FQHCs and LALs that are not already members.	Q1 BP4
Clearly define the benefits of PCEPN membership	Review survey results and incorporate updates to benefits list.	Q1 BP4
Communicate benefits of PCEPN membership to potential members	Update PCEPN website and include in all recruitment materials.	Q2 BP4
Implement BCP recruitment messaging/strategy to add members	Leverage existing relationships and use direct communications (i.e., phone, in-person meetings) to reach executive level and EM staff at target networks.	Throughout BP4 and BP5
Work with partners, such as the NYC Medical Reserve Corps (MRC) and county medical societies, to indirectly recruit medical groups	Leverage existing relationships and use direct communications (i.e., phone, in-person meetings). Share information on PCEPN with partners' members through newsletter articles, e-mails, and/or presentations at their meetings.	Throughout BP4 and BP5
Cross-recruit providers in partnership with the PCIP	Leverage existing relationships and use direct communications (i.e., phone, in-person meetings). Share information on PCEPN with partners' members through newsletter articles and/or e-mails.	Throughout BP4 and BP5
Increase visibility of PCEPN programs and member support efforts through participation in health care coalition meetings and ongoing participation in ESF-8 planning meetings	Attend meetings and share the work PCEPN is doing, as well as the benefits it offers to members.	Throughout BP4 and BP5

Action Item	Methods	Anticipated Timing
Reengage existing PCEPN members	Update PCEPN website to add reports and TA guidance/ documents. Improve mailing list functionality through use of *Constant Contact.* Expand the *HC Standard* communication platform to enhance situational awareness. Offer 2 new BCP workshops. Use core activities, e.g., communications drills and trainings to keep members actively participating.	Throughout B4 and BP5 *See Table 6 for a detailed description of core activities for BP4 and BP5*

Table 5. PCEPN Recruitment and Reengagement Activities-BP4 and BP5

VI. Maintenance and Enhancement of Member Preparedness

PCEPN's membership and programming has been building momentum in support of primary care sector preparedness over the last 5 years, as is apparent from its many accomplishments. To maintain and enhance member preparedness during BP4 and BP5, 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 to maintaining and enhancing member preparedness. This approach may be summarized, as follows:

a. **Define roles for primary care.** Together with ESF-8 partners such as DOHMH, NYC EM, and the New York State Department of Health (NYS DOH), we will determine what roles primary care can play in emergency response based on different planning scenarios. This is critical because primary care providers must first understand where they fit into the larger NYC preparedness and response landscape before they may become willing and prepared partners.
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.** Role and capability expectations, taken together with needs identified during assessments, and gaps identified in PCEPN work to date, will inform PCEPN program development. See item 4 below for details on projects planned.
e. **Reassess members every 2-3 years and share results with stakeholders.**

In addition to reevaluation and revision of the Baseline Assessment tool and the initiation of phased reassessments, key activities to support this new approach include the following:

Convene a new Advisory Board to inform program development

PCEPN will convene a new Advisory Board during BP4 to provide valuable insight from the perspective of members on all areas of program development, and bolster planning assumptions. Members of the Advisory Board will be invited to ensure representation from across service areas, services offered, facility types, and tier levels. Ten (10) Advisory Board members will be identified, and 4 meetings will be held each year, on a quarterly basis. Potential Advisory Board functions include: helping to define the target market for PCEPN member recruitment; reevaluation and updating of the tier system and assessment tool; review of critical reports and plans created by PCEPN; advising on an updated HVA during BP5; exercise and training recommendations and planning; delivering training during learning sessions; and participating in PCEPN exercise planning and evaluation. Advisory Board members may also be asked to participate in coalition meetings. Member reassessment and a new Advisory Board will also be used as reengagement activities for existing PCEPN members.

Provide more individualized TA to members

The new Baseline Assessment tool will be used to evaluate all new members in BP4, as well as to begin reassessment of existing members in BP5. Reassessment is expected to be accomplished in phases over the next 2-3 years. When members receive their tier assignment and copy of their assessment, they will also be provided with specific guidance on how to maintain or move up in their tier level. Those in the lowest level will be offered 1:1 coaching sessions focused on those areas of the assessment for which they receive their lowest scores, to assist them with moving up in the tiers. Sessions will include plan review and updating, as well as exercise planning support if requested by the member. Future projects will also be developed with assessment findings in mind to ensure that they track to data elements in the assessment and afford members with opportunities to gain the necessary knowledge and capabilities to move up in tiers.

Provide trainings and exercises to maintain and enhance members' preparedness

The projects completed during BP3 to assess hazards (HVA), identify gaps (e.g., Readiness Project, Ebola Site Visits, Mystery Patient Drills), and test existing plans (IDex tabletop exercise) provide an excellent knowledge base for project planning over the next few years. Pending funding availability (including any residual funding that may become available), PCEPN proposes to offer numerous opportunities for members to participate in PCEPN programming during BP4 and BP5, including:

- Plan and conduct 2-4 half-day business Continuity Workshops for Primary Care Center leadership and EM staff to engage them in emergency management and enhance member preparedness (BP4/BP5)
- Conduct Mystery Patient Drills for at least 15 sites (BP4/BP5 TBD pending funding)
- Conduct 2-4 communications drills with members (BP4/BP5)
- Conduct 2 webinars for members to define roles for primary care in emergency response and inform them of coalition goals to promote community integration and ongoing participation in geographic coalitions (BP4)
- Increase and strengthen primary care linkages within the five newly funded geographic coalitions through coalition participation (BP4/BP5)
- Plan and conduct a full day EM symposium for PCEPN members. Topics will derive from gaps identified in BP3 deliverables (Readiness Project, HVA, EVD Preparedness sites visits, and Mystery Patient Drill Project) (BP4/BP5 TBD pending funding)
- Plan and facilitate a tabletop exercise (TTX) for primary care centers (integration with citywide exercises/collaboration with NYC EM to be explored) (BP5/BP4 pending funding)
- Provide members with a respiratory protection program that includes: fit-testing overview; Train-the-Trainer session; and kits for participating PCCs (BP4 or BP5 pending funding)

Table 6 provides an overview of activities to maintain and enhance PCEPN members' preparedness during BP4 and BP5.

Action Item	Methods	Anticipated Timing
Define roles for primary care and determine capabilities to support roles	Discuss with ESF-8 partners; gather member and Advisory Board feedback; and conduct research	Q1-Q2 BP4
Create an assessment protocol and tools to measure capabilities and assess gaps	Reevaluate and revise Baseline Assessment tool to ensure it is capabilities-based Reevaluate and revise assessment protocols to enhance objectivity Use revised protocol and tool for new member assessments and current member reassessments	Q1 BP4 Q1 BP4 BP4/BP5

Action Item	Methods	Anticipated Timing
Create meaningful content/offer TA to maintain and improve members' preparedness	Use roles, capabilities, gaps identified through assessments and other PCEPN projects previously conducted, along with Advisory Board input to inform program development	BP4/BP5
Convene a new Advisory Board to inform program development	Recruit 10 PCEPN Advisory Board Members by invitation Conduct 4 meetings per year	BP4 BP4/BP5
Provide more individualized TA to members	Provide members with specific guidance on how to maintain or move up in their tier level following assessments Initiate Primary Care Coaching Program for select Tier 3 members Develop future projects with assessment findings in mind to ensure that they track to data elements in the assessment	BP4/BP5 BP5 BP4/BP5
Provide trainings and exercises to maintain and enhance members' preparedness	2-4 half-day business Continuity Workshops Mystery Patient Drills for at least 15 sites 2-4 communications drills with members 2 webinars for members to define roles for primary care in emergency response and promote community integration Member participation in health care coalitions Full day EM symposium for PCEPN members Tabletop exercise (TTX) for primary care centers Respiratory protection program	BP4/BP5 BP4/BP5 BP4/BP5 BP4 BP4/BP5 BP4 (BP5 pending funding) BP4 (BP5 TBD pending funding) BP5 (BP4 pending funding)

VII. Challenges

There are several important challenges to recruiting new members, and maintaining and enhancing current member preparedness, which must be noted in this plan.

Staff turnover

Due to the high staff turnover seen at member sites, PCEPN needs to continuously reengage members and retrain them on EM fundamentals.

Promoting work without mandates

While members must comply with guidance on EM program development and requirements from regulatory and accrediting bodies, they are not required to participate in PCEPN, or in any of the activities offered to them after becoming members.

Members need TA and 1:1 support to successfully implement their EM programs

Members require support to maintain their EM programs due to insufficient EM funding, dedicated staff, and time. This includes planning and completing exercises and after action review; providing adequate and appropriate EM training for staff; hazard analysis; and protocol and plan development. They need the templates and training PCEPN can provide, but they also need PCEPN staff to provide TA to successfully implement their EM programs.

Uncertainty in funding

PCEPN relies on the partnership between CHCANYS, PCDC, and DOHMH, as well as on federal funding administered through DOHMH to sustain PCEPN. Funding is not guaranteed at historical levels, or even at all from year to year. PCEPN is slated to receive a 20% cut in funding for BP4. PCEPN cannot fund communications platform licenses, equipment/supply purchases, or incentives for members to participate without funding. Decreased funding could lead to decreased PCEPN staffing. Decreased staffing could result in a limited ability to develop and deliver TA; the elimination of exercises and live trainings; and could significantly hinder PCEPN's ability to staff the ESF-8 desk during emergencies. PCEPN would have a member contact list but it would be difficult to ensure accuracy of the contact information due to a likely decrease in communications drills and regular information sharing with members, both of which help to test contact information. Incomplete or inaccurate contact information will make communication and situational awareness less reliable during emergencies. With decreased or no funding, PCEPN would only be able to have pre-loaded content on its website, but it would be very difficult to provide new programming or dedicated TA. Lack of sufficient funding would not only negatively impact membership benefits and readiness for current members, but would also make it extremely difficult to recruit new members, not only due to lack of resources, but also due to lack of perceived (and real) benefit to potential members.

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IX. Appendices

A: PCEPN Member Listing as of May 2015

B: PCEPN Accomplishments by Year—2009-2015

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Appendix A. PCEPN Member Listing as of May 2015

Primary Care Network (PCN)	Number of Sites	Tier	Type of PCN	Hospital Affiliated (Y/N)	Specialty Primary Care (Y/N)
Access Community Health Center	2	1	FQHC	N	N
Apicha Community Health Center	1	1	LAL	N	N
Beacon Christian Community Health Center	1	2	FQHC	N	N
Bedford Stuyvesant Family Health Center, Inc.	6	2	FQHC	N	N
Betances Health Center	1	1	FQHC	N	N
Beth Israel Medical Center - Phillips Ambulatory Care Center	1	1	Primary Care (non-FQHC/LAL)	Y	N
Boriken Health Center (East Harlem Council for Human Services)	1	2	FQHC	N	N
Bronx Community Health Network (BCHN)	15	1	FQHC	Y	N
Brooklyn Plaza Medical Center, Inc.	3	2	FQHC	N	N
Brookdale Family Care Center	6	2	Primary Care (non-FQHC/LAL)	Y	N
Brownsville Multi-Service Family Health Center	7	2	FQHC	N	N
Callen-Lorde Community Health Center	2	3	FQHC	N	N
Care for the Homeless	29	2	FQHC	N	Y
Children's Aid Society	8	3	Primary Care (non-FQHC/LAL)	N	Y
Community Healthcare Network	13	1	FQHC	N	N
Community Health Center of Richmond	2	3	FQHC	N	N
Covenant House	1	1	FQHC	N	N
Damian Family Care Centers	2	1	FQHC	N	N
Dr. Martin Luther King, Jr. Health Center	8	1	FQHC	Y	N
Floating Hospital	13	2	FQHC	N	N
Harlem United (Upper Room Aids Ministry)	3	3	FQHC	N	N
Healthcare Choices	2	3	FQHC	N	N
Housing Works	3	2	FQHC	N	N
Institute for Family Health (IFH)	11	2	FQHC	N	N

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Primary Care Emergency Preparedness Network

Primary Care Network (PCN)	Number of Sites	Tier	Type of PCN	Hospital Affiliated (Y/N)	Specialty Primary Care (Y/N)
Joseph P Addabbo Family Health Center	6	2	FQHC	N	N
Kingsbrook Jewish Medical Center	2	2	Primary Care (non-FQHC/LAL)	Y	N
Lutheran Family Health Center	25	1	FQHC	Y	N
Maimonides Primary Care Network	9	1	Primary Care (non-FQHC/LAL)	Y	N
MediSys	10	1	Primary Care (non-FQHC/LAL)	Y	N
Metro Community Health Center (Formerly Cerebral Palsy Association of NYS)	4	2	Primary Care (non-FQHC/LAL)	N	Y
Montefiore Medical Group (MMG)	29	1	Primary Care (non-FQHC/LAL)	Y	N
Morris Heights Health Center	21	1	FQHC	N	N
Morrisania Diagnostic and Treatment Center (Gotham Health)	1	2	LAL	Y	N
New York Hospital Queens (The Department of Community Medicine)	17	1	Primary Care (non-FQHC/LAL)	Y	N
ODA Primary Health Care Network	5	2	FQHC	N	N
Segundo Ruiz Belvis Diagnostic and Treatment Center (Gotham Health)	1	1	LAL	Y	N
Settlement Health	1	2	FQHC	N	N
South Bronx Health Center	1	N/A	Primary Care (non-FQHC/LAL)	Y	N
Union Community Health Center	3	1	FQHC	N	N
William F. Ryan Community Health Center	16	1	FQHC	N	N
Renaissance Diagnostic and Treatment Center (Gotham Health)	1	2	LAL	Y	N
Ryan/Chelsea Clinton Community Health Center	1	1	FQHC	N	N
Wyckoff Heights Medical Center Ambulatory Care	3	1	Primary Care (non-FQHC/LAL)	Y	N

PCEPN
Primary Care Emergency Preparedness Network

Appendix B: PCEPN Accomplishments by Year—2009-2015

2009-2010

- Conceptual development of PCEPN through PCDC and CHCANYS H1N1 response coordination

2010-2011

- Defined PCEPN's mission and organization through signed MOU between CHCANYS and PCDC
- Conducted a Hazard Vulnerability Analysis (HVA) for the NYC primary care sector
- Updated emergency activation manual to include communication protocols among PCEPN, DOHMH, and NYC EM
- Successfully advocated for primary care and secured a seat in the citywide EOC during ESF-8 activations to represent PCCs
- Held strategic planning workshop with DOHMH, NYC EM, and PCCs focused on refining PCEPN's mission and scope
- Conducted training and exercise workshops and developed HSEEP-compliant multi-year training and exercise plan
- Developed a data management plan for the collection and maintenance of PCEPN members' contact info

2011-2012

- Developed a system to assign members to tiers based on capabilities and level of participation
- Conducted baseline assessments for all members and assigned them to tiers
- Established PCEPN Advisory Board
- Developed a PCEPN emergency preparedness toolkit, including Business Continuity Plan (BCP) and exercise development and reporting templates
- Launched PCEPN website
- Revised POD guidance documents and Emergency Operations Plan (EOP) template
- Provided technical assistance to PCCs to help them develop facility-specific EOPs and BCPs, and to utilize exercise documents to conduct an exercise
- Launched EverBridge communication system and developed communication protocols to support it
- Conducted communications drill with PCEPN members
- Conducted internal PCEPN communications drill to test communication and coordination for EOC staffing
- Created a site-specific community partner and resource catalog for Tier 1 members
- Established representation of primary care in citywide ESF-8 planning meetings

- Introduced training on HVAs; EM basics for Primary Care Centers; Risk Communications; Staff Training; Evaluation and Corrective Action Planning; NYC Pandemic & Evacuation Plans; and Partnership Facilitation, Resource and Volunteer Management
- Supported PCCs from PCEPN's ESF-8 seat during Hurricane Irene

2012-2013

- Conducted workshops with PCCs and community partners to enhance community integration of PCCs
- Worked with the Advisory Board to develop a 5-year strategic plan for PCEPN
- Supported PCCs from PCEPN's ESF-8 seat during Superstorm Sandy
- Created Tier-specific course catalog for members on the PCEPN website
- Incorporated lessons learned from Superstorm Sandy response After Action Report (AAR) into EOC activations manual and trained PCEPN staff on revised protocols
- Assisted 10 PCCs affected by Superstorm Sandy with AAR development

2013-2014

- Integrated 7 PCNs into PCEPN, hospitals, and/or DOHMH exercises
- Developed summary of preparedness gaps, best practices, and recommendations utilizing members' baseline assessment data
- Trained members on drill design and execution and assisted 7 network members to develop an exercise focused on addressing Superstorm Sandy response gaps and continuity of operations during emergencies
- Updated course catalog based on gaps identified in the 2012 baseline assessments; Superstorm Sandy AARs; and 2010 HVA
- Delivered 7 trainings to members focused on Incident Command System (ICS); NYC Coastal Storm Plan; Social Media in Emergencies; Psychological First Aid; Points of Dispensing (PODs); and Resource Requests During Emergencies
- Conducted Community Integration and Resiliency workshop to build upon the progress resulting from earlier workshops

2014-2015

- Conducted 3 Readiness Project focus groups with members and developed a final report of findings to identify the current state of readiness of the primary care sector in New York City (NYC); establish readiness targets and mechanisms for achieving those targets; and determine future PCEPN primary care sector emergency management strategies, projects, and training initiatives to close the gaps identified
- Conducted a new primary care sector HVA utilizing PCEPN members as proxy for the NYC primary care sector

- Expanded use of HC Standard communications platform among non-FQHC members
- Conducted 2 communications drills with members
- Created a Webinar on "Emergency Management for Primary Care Centers" and posted it to NYS LMS
- Organized and conducted a full-day Primary Care Sector Emergency Management Conference for members and stakeholders
- Created plan templates for Coastal Storms and Infectious Disease Outbreaks response
- Conducted tabletop exercise with 11 network members focused on an extended infectious disease outbreak and including a Coastal Storm
- Conducted 61 Ebola Site Visits to review plans with members and offer technical assistance to improve them
- Conducted 21 Mystery Patient Drills to test members' and leading NYC urgent care providers' knowledge and utilization of screening and isolation protocols for infectious diseases
- Created an Action and Sustainability Plan to define how PCEPN will expand its membership and maintain preparedness among its members