PCEPN
Primary Care Emergency Preparedness Network

Primary Care Mystery Patient Drill Series

Master After-Action Report/Improvement Plan

May 2016

EXERCISE OVERVIEW

Exercise Name	Primary Care Mystery Patient Drill Series (2016)
Exercise Dates	March 28, 2016 - April 8,2016
Scope	The 2016 Primary Care Mystery Patient Drill Series was conducted at 15 primary care center sites in New York City from March 28, 2016 to April 8, 2016. The exercises tested the ability of participating primary care centers to follow their infection control plans when faced with a potentially infectious patient. Unannounced drills were conducted in a realistic, real-time environment until exercise objectives were met or when the actor "patient" (played by a NYC Medical Reserve Corps volunteer) was about to be subjected to real tests or examination.
Mission Area(s)	Response
Core Capabilities	• Healthcare System Preparedness • Responder Safety and Health
Objectives	1. Assess the ability of the primary care center to appropriately screen a potentially infectious patient. 2. Assess the ability of the primary care center to appropriately isolate a potentially infectious patient.
Threat or Hazard	Infectious Disease Outbreak
Scenario	A potentially infectious patient presenting with influenza-like illness (ILI) at a primary care center. Patient is accompanied by a friend/family member.
Sponsor	This publication was supported by Cooperative Agreement Number 5U90TP000546-04 from the Centers for Disease Control and Prevention and/or Assistant Secretary for Preparedness and Response. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention and/or the Assistant Secretary for Preparedness and Response.

Participating Organizations	1. NYC Health +Hospitals Metropolitan – La Clinica del Barrio 2. ODA Primary Health Care Network 3. Morris Heights Health Center 4. Community Healthcare Network 5. Housing Works Community Healthcare 6. Brooklyn Plaza Medical Center, Inc. 7. Harlem United 8. Joseph Addabbo Family Health Center 9. Metro Community Health centers 10. Damian Family Health Center 11. Brownsville Multi Service Health Center 12. NYC Health +Hospitals Coney Island Hospital- Ida G Israel Community Health Center 13. Northwell Health- Department of Otolaryngology at Long Island Jewish Medical Center 14. East Harlem Council for Human Services, Inc. (Boriken Health Center) 15. City MD
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In 2016, PCEPN's Mystery Patient Drill Project was carried out at 15 distinct primary care centers (sites). Each participating Primary Care Center (PCC) assigned a Drill Team comprised of PCC Staff (in most cases a clinical nurse, a quality improvement staff as well as administrative support staff). Drill Teams were provided with a Mystery Patient Drill Kit containing the following templates/resources:

- Mystery Patient Drill Exercise Plan
- Master Scenario Event List (MSEL)
- Exercise Evaluation Guide (EEG)
- Hotwash Guide
- Participant Feedback Form
- After Action Report (AAR)

PCEPN worked with NYC Medical Reserve Corps (NYC MRC) to identify a volunteer, who played the role of the "patient". PCEPN and PCC Drill team members utilized the Exercise Evaluation Guide (EEG) in the on-site evaluation of the drills. After each drill, PCEPN team members also facilitated an on-site hotwash with all participating staff members and the MRC Volunteer. During the hotwash, participants completed the feedback forms. Each participating PCC completed an AAR and submitted the report to PCEPN. The information contained in this Master AAR is derived from

the completed EEGs, AARs, hotwash guides, and participant feedback forms collected on-site and/or shared after the drill's conclusion.

ANALYSIS OF CORE CAPABILITIES

Table 1 includes the exercise objectives, aligned core capabilities, and performance ratings for each core capability as observed during the exercise and determined by the evaluation team. All data included in this AAR is aggregate for the 15 drills conducted. Information presented includes number of PCCs rated and percentage of total.

Objective	Core Capability	Performed without Challenges (P) N=15	Performed with Some Challenges (S) N=15	Performed with Major Challenges (M) N=15	Unable to be Performed (U) N=15
1. Assess the ability of the primary care center to appropriately screen a potentially infectious patient.	Healthcare System Preparedness	11 (73%)	4 (27%)	-	-
2. Assess the ability of the primary care center to appropriately isolate a potentially infectious patient.	Responder Safety and Health & Healthcare System Preparedness	8 (53%)	7 (47%)	-	-

Ratings Definitions:

- Performed without Challenges (P): The targets and critical tasks associated with the core capability were completed in a manner that achieved the objective(s) and did not negatively impact the performance of other activities. Performance of this activity did not contribute to additional health and/or safety risks for the public or for emergency workers, and it was conducted in accordance with applicable plans, policies, procedures, regulations, and laws.
- Performed with Some Challenges (S): The targets and critical tasks associated with the core capability were completed in a manner that achieved the objective(s) and did not negatively impact the performance of other activities. Performance of this activity did not contribute to additional health and/or safety risks for the public or for emergency workers, and it was conducted in accordance with applicable plans, policies, procedures, regulations, and laws. However, opportunities to enhance effectiveness and/or efficiency were identified.
- Performed with Major Challenges (M): The targets and critical tasks associated with the core capability were completed in a manner that achieved the objective(s), but some or all of the following were observed: demonstrated performance had a negative impact on the performance of other activities; contributed to additional health and/or safety risks for the public or for emergency workers; and/or was not conducted in accordance with applicable plans, policies, procedures, regulations, and laws.
- Unable to be Performed (U): The targets and critical tasks associated with the core capability were not performed in a manner that achieved the objective(s).

Table 1. Summary of Core Capability Performance

The following sections provide an overview of the performance related to each exercise objective and associated core capability, highlighting strengths and areas for improvement overall. Evaluation tools for individual sites have been provided to each participating primary care center to ensure that site-specific lessons learned are incorporated into plan and policy updates, and future training and exercises.

Objective 1: Assess the ability of the primary care center to appropriately screen a potentially infectious patient

The strengths and areas for improvement for each core capability aligned to this objective are described in this section.

Healthcare System Preparedness

Strengths

The partial capability level observed can be attributed to the following strengths:

Strength 1: PCC staff members have been trained to **screen** patients for symptoms of communicable disease.

Strength 2: Response among PCC staff members was prompt (average 3.5 minutes) and included effective cross-departmental communication.

Strength 3: Personal protective equipment (PPE) is available in reception areas to be provided to patients at the point of screening.

Areas for Improvement

The following areas require improvement to achieve the full capability level:

Area for Improvement 1: Patients reporting symptoms of communicable disease are not consistently provided with a mask; potentially infectious patients that are not given a mask present increased exposure risk to PCC staff and patients while in common areas such as waiting rooms.

Reference: NYC DOHMH Guidance Document for Development of Protocols for Management of Patients Presenting to Hospital Emergency Departments and Clinics with Potentially Communicable Diseases of Public Health Concern (NYC DOHMH Guidance)

Analysis: Current protocols do not contain specific criteria for screening patients and/or providing patients with masks. Staff members have not been trained on the PCC's screening and isolation protocol. PCCs do not have signage to indicate masks are available.

Area for Improvement 2: When provided with a mask, patients are not consistently provided with instructions about how/when to wear the mask, or why it is being provided.

Reference: NYC DOHMH Guidance Document for Development of Protocols for Management of Patients Presenting to Hospital Emergency Departments and Clinics with Potentially Communicable Diseases of Public Health Concern (NYC DOHMH Guidance)

Analysis: Current protocols do not contain specific steps for providing patients with instructions on wearing masks. Staff member training may need to be further improved to include a component of patient education.

Area for Improvement 3: Staff need additional training on respiratory protection programs available at their PCCs, including appropriate use of masks/respirators.

Reference: Occupational Safety and Health Administration (OSHA) Standard 1910.134- Respiratory Protection.

Analysis: Current protocols need improvement to clarify appropriate use of masks/ respirators. Staff member training needs to be further improved to include this component.

Objective 2: Assess the ability of the primary care center to appropriately isolate the potentially infectious patient

The strengths and areas for improvement for each core capability aligned to this objective are described in this section.

Responder Safety and Health & Healthcare System Preparedness

Strengths

The partial capability level observed can be attributed to the following strengths:

Strength 1: PCC staff members have been mostly trained to **isolate** patients with a positive screening for communicable disease.

Strength 2: Ongoing communication among PCC staff members supports the prompt isolation of patients upon identification and/or screening.

Strength 3: PCCs have identified isolation rooms, PPE, and infection control requirements for patients placed in isolation.

Areas for Improvement

The following areas require improvement to achieve the full capability level:

Area for Improvement 1: Awareness of isolation precautions/requirements.

Reference: NYC DOHMH Guidance Document for Development of Protocols for Management of Patients Presenting to Hospital Emergency Departments and Clinics with Potentially Communicable Diseases of Public Health Concern (NYC DOHMH Guidance)

Analysis: Clarification is needed on DOHMH guidance to better understand current recommendations and revise/update PCCs' protocols to address these recommendations; although staff training in isolation precautions and requirements is present, further improvement in training is needed to ensure application of protocols is consistent.

Area for Improvement 2: Signage was not posted to indicate the isolation room was occupied by a patient under investigation for communicable disease.

Reference: NYC DOHMH Guidance Document for Development of Protocols for Management of Patients Presenting to Hospital Emergency Departments and Clinics with Potentially Communicable Diseases of Public Health Concern (NYC DOHMH Guidance)

Analysis: Staff relied on verbal communication to inform other staff that the room was occupied.

Area for Improvement 3: Patient isolated was not provided with complete information on the process, why it was occurring, and expected outcomes.

Reference: NYC DOHMH Guidance Document for Development of Protocols for Management of Patients Presenting to Hospital Emergency Departments and Clinics with Potentially Communicable Diseases of Public Health Concern (NYC DOHMH Guidance)

Analysis: Staff focused on addressing the developing situation that required application of infection control protocols, i.e. isolation, while failing to educate patients on the reasons for initiating the isolation process.

In addition to the Analysis of Core Capabilities, PCEPN highlighted select key findings which can be used to compare individual PCC performance and assess improvement over time:

Key Finding	2015 Results (n=21)	2016 Results (n=15)
Average waiting time between initial entry to PCC and triage (patient escorted to evaluation/ isolation area).	8.5 minutes	3.5 minutes
Patient was offered a mask by the first point of contact within the PCC.	47%	73%
Patient's disposition after triage was to be held in the isolation area until further evaluation by a medical provider.	90%	100%

Table 1. Analysis of performance improvement by year

APPENDIX A: IMPROVEMENT PLAN

This IP has been developed specifically for PCEPN as a result of the Primary Care Mystery Patient Drill Series conducted from March 28, 2016 to April 8, 2016. AARs submitted to PCEPN identified dates ranging from April to June 2016. Individual site AARs should be used to guide PCCs as to which corrective actions are needed.

Core Capability	Issue/Area for Improvement	Corrective Action	Capability Element[1]	Primary Responsible Organization	Organization POC	Start Date	Completion Date
Healthcare System Preparedness & Responder Safety and Health	Common issues identified in AARs submitted by PCCs including (but not limited to): Staff training, PPE, hand hygiene, signage, triage processes, and protocols.	Promote use of checklist of common issues which can be used by PCCs as a guide for protocol development, revisions and updates.	Planning	PCEPN	Alexander Lipovtsev	June 1, 2016	June 30, 2016
Healthcare System Preparedness & Responder Safety and Health	Training needs identified in AARs submitted by PCCs including respiratory protection programs and use of masks/respirators.	Provide training and resources to PCCs regarding the Respiratory Protection and fit-testing.	Training	PCEPN	Alexander Lipovtsev	May 12, 2016	June 30, 2016
Healthcare System Preparedness & Responder Safety and Health	Training needs identified in AARs submitted by PCCs including (but not limited to): PPE, providing patient instructions, and isolation precautions.	Incorporate training issues identified into PCEPN webinar and full day seminar planned for Budget Period 5 (2016-2017).	Training	PCEPN*	Alexander Lipovtsev	July 1, 2016	June 30, 2017

*PCEPN activities are contingent upon funding administered by DOHMH

APPENDIX B: EXERCISE PARTICIPANTS

Participating Organizations
Primary Care Emergency Preparedness Network/Community Healthcare Association of New York State
NYC Health +Hospitals Metropolitan – La Clinica del Barrio
ODA Primary Health Care Network
Morris Heights Health Center
Community Healthcare Network
Housing Works Community Healthcare
Brooklyn Plaza Medical Center, Inc.
Harlem United
Joseph Addabbo Family Health Center
Metro Community Health centers
Damian Family Health Center
Brownsville Multi Service Health Center
NYC Health +Hospitals Coney Island Hospital- Ida G Israel Community Health Center
Northwell Health - Department of Otolaryngology at Long Island Jewish Medical Center
East Harlem Council for Human Services, Inc. (Boriken Health Center)
City MD
NYC Medical Reserve Corps (MRC)