

# Primary Care Mystery Patient Drill Series – Phase 3

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Master After-Action Report / Improvement Plan  
January 2017

## EXERCISE OVERVIEW

<b>Exercise Name</b>	Primary Care Mystery Patient Drill Series (Phase 3)
<b>Exercise Dates</b>	November 28, 2016 – December 9, 2016
<b>Scope</b>	The 2016-2017 Primary Care Mystery Patient Drill Series (Phase III) was conducted at 16 primary care center sites in New York City from November 28, 2016 to December 9, 2016. The exercise tested the ability of primary care centers to follow their infection control plans when faced with a potentially infectious patient. This unannounced drill was conducted in a realistic, real-time environment until exercise objectives were met or when the “mystery patient” (NYC Medical Reserve Corps volunteer actor) was about to be subjected to real tests or examination.
<b>Mission Area(s)</b>	Response
<b>Core Capabilities</b>	<p>The below associated core capabilities are based on the Office of the Assistant Secretary for Preparedness and Response’s (ASPR) Healthcare Capabilities List<sup>1</sup>: National Guidance for Healthcare System Preparedness (2012-2017).</p> <ul style="list-style-type: none"> <li>• Healthcare System Preparedness</li> <li>• Responder Safety and Health</li> </ul>
<b>Objectives</b>	<ol style="list-style-type: none"> <li>1. Assess the ability of the primary care center to appropriately <b>screen</b> a potentially infectious patient within 10 minutes from check in with reception.</li> <li>2. Assess the ability of the primary care center to appropriately <b>isolate</b> the potentially infectious patient within 10 minutes after screening.</li> </ol>
<b>Threat or Hazard</b>	Infectious Disease Outbreak
<b>Scenario</b>	A potentially infectious patient presenting with influenza-like illness (ILI) at a primary care center. Patient is accompanied by a friend/family member.
<b>Sponsor</b>	<i>This publication was supported by Cooperative Agreement Number NU90TP000546-05 from the Centers for Disease Control and Prevention (CDC) and/or Assistant Secretary for Preparedness and Response. Its contents are solely the responsibility of the authors and do not necessarily</i>

<sup>1</sup> <http://www.phe.gov/preparedness/planning/hpp/reports/documents/capabilities.pdf>

	<i>represent the official views of the Centers for Disease Control and Prevention and/or the Assistant Secretary for Preparedness and Response.</i>
<b>Participating Organizations</b>	<ol style="list-style-type: none"> <li>1. Bedford-Stuyvesant Family Health Center</li> <li>2. Betances Health Center</li> <li>3. Brooklyn Plaza Medical Center, Inc.</li> <li>4. Community Health Center of Richmond</li> <li>5. Community Healthcare Network</li> <li>6. Covenant House</li> <li>7. Harlem United</li> <li>8. Housing Works Community Healthcare</li> <li>9. Institute for Family Health</li> <li>10. Joseph P. Addabbo Family Health Center</li> <li>11. Metro Community Health Centers</li> <li>12. Morris Heights Health Center</li> <li>13. NYC Health + Hospitals – Gotham Health Cumberland</li> <li>14. NYC Health + Hospitals – Gotham Health Segundo Ruiz Belvis</li> <li>15. NYC Health + Hospitals – Gotham Health East New York</li> <li>16. William F. Ryan Health Center</li> <li>17. New York City Medical Reserve Corps (NYC MRC)</li> <li>18. New York City Department of Health and Mental Hygiene (DOHMH)</li> <li>19. Community Health Care Association of New York State (CHCANYS) / Primary Care Emergency Preparedness Network (PCEPN)</li> </ol>
<b>Points of Contact</b>	<p><b>Name:</b> Alexander Lipovtsev, LCSW</p> <p><b>Title:</b> Assistant Director, Emergency Management</p> <p><b>Agency:</b> Community Health Care Association of New York State</p> <p><b>Address:</b> 111 Broadway Suite 1402, New York, NY 10006</p> <p><b>Office:</b> (212) 710-4192</p> <p><b>E-mail:</b> alipovtsev@chcanys.org</p>

## INTRODUCTION

The Primary Care Emergency Preparedness Network (PCEPN) is a coalition of primary care providers in New York City (NYC). It is led by Community Health Care Association of New York State ([CHCANYS](#)) in close partnership with NYC Department of Health and Mental Hygiene ([DOHMH](#)). PCEPN supports primary care emergency preparedness and response activities. Its mission is to increase the ability of the NYC primary care community to prepare for, respond to, and recover from disasters, as well as to ensure that primary care is represented in citywide planning and response. PCEPN has representatives from Federally Qualified Health Centers (FQHC), 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<sup>2</sup>.

PCEPN's Phase III Mystery Patient Drill Project was carried out at 16 distinct primary care centers/sites (PCC) across the five boroughs of New York City ([Appendix C](#)); Participating sites are Federally Qualified Health Centers (FQHCs)<sup>3</sup>. Each PCC assigned a Drill Team comprised of PCC staff (in most cases a nurse, a quality improvement staff member, as well as administrative/support staff member i.e. clinical and non-clinic staff persons). 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)/ Improvement Plan (IP)
- Mystery Patient Drill Screening/Isolation Protocol Checklist

PCEPN worked in close coordination with NYC Medical Reserve Corps (NYC MRC) to identify a volunteer, to serve as an actor in the role of the "mystery patient" on the day of the drill. 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 debriefing session (also referred to as a "hotwash") with all participating staff members and the MRC volunteer. During the hotwash, participants completed and provided feedback forms. Each participating PCC completed an AAR/IP 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 drills' conclusion.

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<sup>2</sup> For more information about PCEPN, visit [www.pcepn.org](http://www.pcepn.org)

<sup>3</sup> <https://bphc.hrsa.gov/about/what-is-a-health-center/index.html>

## 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 teams (PCC drill teams and PCEPN). This AAR includes aggregate data for the 16 drills conducted. Information presented includes number of PCCs rated and percentage of total.

Objective	Core Capability	Performed without Challenges (P) N=16	Performed with Some Challenges (S) N=16	Performed with Major Challenges (M) N=16	Unable to be Performed (U) N=16
1. Assess the ability of the primary care center to appropriately screen a potentially infectious patient within 10 minutes from check in with reception.	Healthcare System Preparedness	12 (75 %)	1 (6 %)	3 (19 %)	-
2. Assess the ability of the primary care center to appropriately isolate the potentially infectious patient within 10 minutes after screening.	Responder Safety and Health & Healthcare System Preparedness	11 (69 %)	4 (25 %)	-	1 (6 %)
<b>Ratings Definitions:</b> <ul style="list-style-type: none"> <li>• <b>Performed without Challenges (P):</b> 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.</li> <li>• <b>Performed with Some Challenges (S):</b> 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.</li> <li>• <b>Performed with Major Challenges (M):</b> 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.</li> <li>• <b>Unable to be Performed (U):</b> The targets and critical tasks associated with the core capability were not performed in a manner that achieved the objective(s).</li> </ul>					

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 planning updates, as well as included in primary care centers' training & exercise programs.

## **Objective 1: Assess the ability of the primary care center to appropriately screen a potentially infectious patient within 10 minutes from check in with reception.**

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:** Primary Care Centers demonstrated that organizational infection control plans have been largely established. These plans allow for rapid appropriate screening of patients for symptoms of communicable disease.

**Strength 2:** Primary Care Centers demonstrate strong team communication patterns (e.g. reception to nursing, nursing to reception, nursing to physician, etc.) to relay relevant important information across departments to expedite prompt response to address potential communicable disease.

**Strength 3:** Personal protective equipment (PPE) (e.g. surgical masks, alcohol hand hygiene products) 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:** Electronic health records (EHRs) may be a hindrance in initiating appropriate screening protocols.

**Analysis:** In at least two locations, the electronic health record (EHR) workflow impeded the screening protocols. Patients arriving into the practice need to be registered into the EHR (for reimbursement, documentation etc.). The travel history questions are part of a "record screen, aka. layout" in the EHR that comes up when the patient is taken vital signs. Since it may take time for registration and creating a record to allow a patient being seen, it may affect the rapidity of the screening/isolation.

**Area for Improvement 2:** Appropriate signage on communication diseases is not appropriately displayed.

**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:** Signage about communicable diseases, and especially, relevant travel history, needs to be more prominently displayed and easily recognizable. Although primary care centers do post appropriate signs, some of the signage locations may not be ideal and overlooked by patients as they are lost among a multitude of other posted information and are very hard to see.

**Area for Improvement 3:** Staff need additional in-depth training on appropriate use of masks / respirators.

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

**Analysis:** Not all primary care centers were able to provide appropriate respiratory protection to a patient at the first point of contact. Also, instructions on how to put a mask on appropriately and what to do with it (i.e. keep it on, call for assistance if needed, etc.), were not always provided to the patient.

**Area for Improvement 4:** PCCs do not have clear protocols for companions of a potentially infectious patient coming into the facility.

**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); Organization specific policies and procedures.

**Analysis:** Not all primary care centers have clear policies and protocols on what to do with when a patient displaying signs and symptoms of a communicable disease arrives with a companion. This lack of guidance sometimes creates confusion for both front-line and clinical staff, and may lead to inadequate interventions to prevent potential transmission.

## **Objective 2: Assess the ability of the primary care center to appropriately isolate the potentially infectious patient within 10 minutes after screening.**

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 are largely trained on how to appropriately **isolate** patients with a positive screening for communicable disease.

**Strength 2:** All PCCs have identified appropriate isolation rooms and personal protective equipment when dealing with patients with potential communicable disease.

**Strength 3:** PCCs have demonstrated ability to initiate and utilize internal isolation protocols with patients who screened positively, rather to turn them away to refer them to another facility (e.g. emergency room, urgent care center, etc.)

## Areas for Improvement

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

**Area for Improvement 1:** PCCs need to utilize stricter controls when their isolation rooms are in use.

**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:** Although most PCCs were able to rapidly isolate patients, who screened positively for potential communicable disease, isolation rooms need stricter controls, i.e. signage that the room is occupied, coming in and out of the room, utilization of the ante-room/doffing area, communications protocols with patients in isolation, etc.

**Area for Improvement 2:** Considerations for the psychological impact rapid isolation process may have on a patient.

**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:** Patients, who are being isolated, need to be better informed about the process. Lack of information about what is happening and why may lead to a “walkout” by the patient (i.e. incomplete medical evaluation), or cause unnecessary anxiety to them or their companions.

**Area for Improvement 3:** PCCs need to improve directions provided to patients in isolation.

**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:** PCC staff mostly focused on appropriately isolating a patient, sometimes forgetting to remind isolated patients about hand hygiene standards and also what to do if the patient needed assistance with utilizing a restroom.

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)	2017 Results (N=16)
Average waiting time between initial entry to PCC and triage (patient escorted to evaluation/ isolation area).	8.5 minutes	3.5 minutes	3.46 minutes
Patient was offered a mask by the first point of contact within the PCC.	47%	73%	75%

Table 2. Analysis of performance improvement by year



## APPENDIX A: IMPROVEMENT PLAN

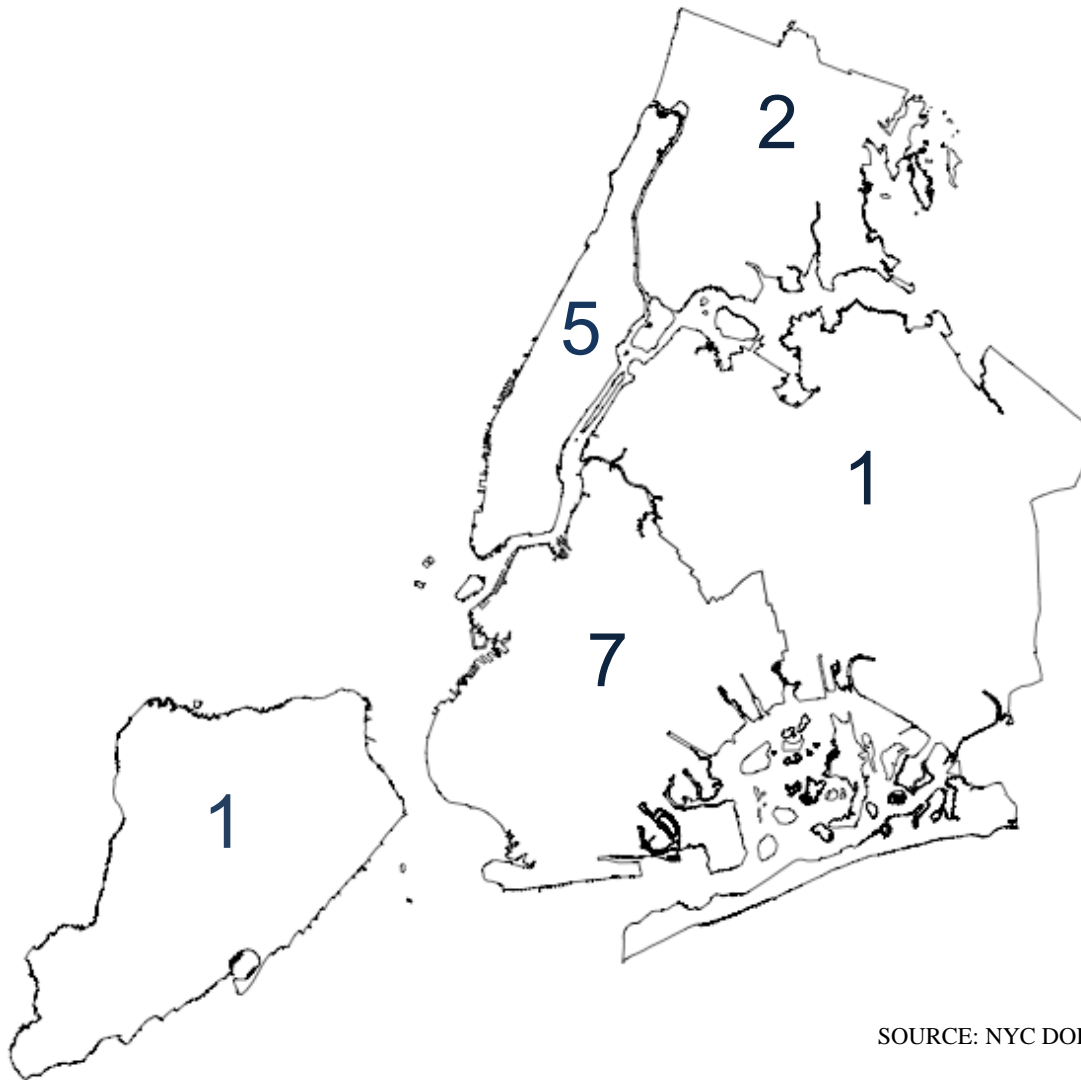
This IP has been developed specifically for PCEPN as a result of the Primary Care Mystery Patient Drill Phase 3 Series conducted from November 28, 2016 – December 9, 2016. AARs submitted to PCEPN identified dates ranging from December 1 to December 23, 2016. Individual site AARs should be used to guide PCCs as to which corrective actions are needed.

Core Capability	Issue/Area for Improvement	Corrective Action	Capability Element	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 and hand hygiene, ongoing exercises of plans, review of current workflows for improvement.	Promote NYC DOHMH Guidance Document and PCEPN Checklist for ongoing protocol development, revisions and updates.	Planning	PCEPN	Alexander Lipovtsev	February 1, 2017	June 30, 2017
Healthcare System Preparedness & Responder Safety and Health	Equipment needs identified in AARs submitted by PCCs including appropriate signage resources to use for reception areas and Isolation Rooms.	Provide signage resources to PCCs to use for reception areas and Isolation Rooms.	Equipment	PCEPN	Alexander Lipovtsev	February 1, 2017	February 28, 2017
Healthcare System Preparedness & Responder Safety and Health	Exercise needs identified in AARs submitted by PCCs including (but not limited to): need for ongoing exercise cycle to facilitate improvement cycle and staff training.	Provide PCCs with exercise resources including (but not limited to) webinar recordings, exercise modifiable templates and other relevant documents.	Exercise	PCEPN	Alexander Lipovtsev	February 1, 2017	February 28, 2017

## APPENDIX B: EXERCISE PARTICIPANTS

Participating Organizations (n=19)	Sites in Network (n=145)	PCEPN Tier Level
1. Bedford Stuyvesant Family Health Center	7	2
2. Betances Health Center	1	1
3. Brooklyn Plaza Medical Center, Inc.	3	2
4. Community Health Center of Richmond	2	3
5. Community Healthcare Network	14	1
6. Covenant House	1	1
7. Harlem United	5	3
8. Housing Works Community Healthcare	3	2
9. Institute for Family Health	20	2
10. Joseph P. Addabbo Family Health Center	6	2
11. Metro Community Health Centers	3	2
12. Morris Heights Health Center	25	1
13. NYC Health + Hospitals – Gotham Health Cumberland	40	1
14. NYC Health + Hospitals – Gotham Health Segundo Ruiz Belvis		
15. NYC Health + Hospitals – Gotham Health East New York		
16. William F. Ryan Health Center	15	1
17. Primary Care Emergency Preparedness Network	N/A	N/A
18. New York City Department of Health and Mental Hygiene	N/A	N/A
19. New York City Medical Reserve Corps	N/A	N/A

## APPENDIX C: GEOGRAPHIC DISTRIBUTION OF EXERCISE PARTICIPANTS



SOURCE: NYC DOHMH

Number of participating sites in Phase 3 Drill per New York City Borough