Expecting the Unexpected: Emergency Preparedness in the Urgent Care Setting

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Picture this: It's a busy day in your urgent care (UC). You're moving along steadily, seeing patients back-to-back. Unexpectedly, there is a commotion as a woman is brought in from the neighborhood right in front of the building. She appears unconscious, and you notice her staggard breathing. No one seems to know what happened prior to finding her on a nearby walking trail and bringing her in for care.

Would your UC team know what to do in this situation? Would you feel prepared to lead?

While large-scale emergency preparedness programs often exist in health systems and hospital settings to address unexpected situations—from sepsis to stroke to mass casualties—UC operators may not have access to emergency preparedness resources tailored to the lean and isolated UC environment. Teams need to be able to respond appropriately to both clinical emergencies as well as threats of physical harm.

UC organizations rarely have plans in place or sufficient hands-on training to ensure the staff can respond to the range of potential emergencies that may arise, such as patients presenting with high-risk pathogens or particularly high-acuity situations like the hypothetical situation above. This article examines how UC centers might systematically approach emergency preparedness and how clinical teams and patients would benefit from standardization across the UC industry as a whole.

High-Risk Pathogens
Patients infected with transmissible pathogens are particularly likely to present to UC centers. A 2022 study found that patients later found to have highly infectious illnesses with potential for community spread, such as

Ebola and mumps, frequently first presented to a UC center.[1] As an initial resource for evaluation and treatment, a UC center's ability to mitigate the risk of spread is a key feature of urgent care's role in emergency preparedness and protection of public health.

The Centers for Disease Control and Prevention has developed an "identify, isolate, and inform" approach, which has been utilized successfully in larger healthcare system settings but can also be adapted to any environment where the risk of encountering these high-risk pathogens exist.[2] Tools such as a hazard vulnerability analysis help provider organizations assess what emergencies may be most likely to affect them and allow for mitigation and emergency preparedness planning.[3] Of note, studies found that failure to implement such programs successfully resulted in more nosocomial infection within the systems studied as well as higher transmission and spread into communities.[3]

There are several key features of effective pathogen-related emergency preparedness plans that apply to UC:

- **Definitive screening:** Creating a culture within the urgent care setting to be aware of possible infectious pathogens and screening for concerning patients regularly is key. Training staff to be informed and communicating information surrounding any emerging pathogens keeps all aware and able to remain diligent.
- **Early identification of possible concerning patients:** Ideally, patients who are a concern for spreading high-risk pathogens should be identified and isolated as early into the visit as possible. This could take the form of screening during registration, alerts when signing in to identify concerning symptoms, or signage in waiting rooms. Being able to remove the patient from the rest of the population in the center and minimizing the number of staff in contact prior to identification helps mitigate spread.
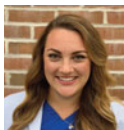
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■ **Incorporation of workflows to guide staff appropriately in times of emergency:** Once identified, the patient needing assessment and treatment should be approached with care and caution. Assuring there are workflows in place for personal protective equipment use and guides on how to properly isolate patients in the setting of highly infectious pathogens is critical for success. Teams should be trained proactively and able to access this information when needed. Workflows on when to trigger a cascade of communication to leadership or local health authorities are also important. If additional resources are needed such as decontamination processes or guidance on testing protocols, it is imperative that teams have effortless access to clinical and operational leaders to facilitate these processes.

High-Acuity Patients

The pandemic exacerbated existing trends of decreased access to primary care providers, and clinician shortages are among the factors that have led to increased acuity of patients in the community.[4] This has resulted in emergency department (ED) crowding and higher-acuity presentations—such as myocardial infarction, respiratory distress, and anaphylaxis—in UC settings.[5] To better prepare UC clinicians and staff for the reality that such higher-acuity patients could present to UC, standardized emergency preparedness training programs are necessary.

Recently, I have been involved in the development of such a program in my organization, Northwell Health Go-Health Urgent Care, and the evolution of an emergency response training team, which we have dubbed "GoPrepare." The GoPrepare program was created to address the need for day-to-day preparedness for the clinical emergencies that may present in our centers.

Score cards for provider and staff performance when participating in this risk-reduction program have shown improvements. The scoring system evaluates the ability of the in-center teams to rapidly identify critically ill patients, intervene quickly, and activate support systems like emergency medical support (EMS) transfer to improve outcomes. We have recorded an increase from an average of 81.5% to 86% on the scorecards across all teams in the training. However, there are many variables, such as new cases presented and additional providers participating, so generally speaking, we use the scores as anecdotal but telling measures of progress.

The GoPrepare Emergency Response team visits UC centers within our organization unannounced and then initiates simulated cardiac arrest or other high-acuity scenarios with the in-center staff and providers. These simulations involve hands-on "mock code" training, in which a mannequin or patient simulator is used to allow for high-fidelity training in situ to best mimic what a real-life emergency scenario might be like.[6] The trainers who run the mock codes also evaluate the clinicians and staff members using our standardized scorecard to track success and areas needing improvement longitudinally. The digital scorecards are used to automatically generate emails that report scores back to the teams in a nonpunitive way. The performance data then provides guidance for continuing provider education. After the simulated scenario is completed, trainers also moderate a structured debriefing session.

Our emergency response team, in addition to leading these simulations, has ensured each center is equipped with appropriate resources for initial response to in-center emergencies. As part of GoPrepare, an automated "lifesaving checklist" form was created, which is reviewed bimonthly by all in-center teams to verify that emergency equipment, such as automated external defibrillators (AEDs) and oxygen supplies, are present, functional, and current.

Operational Concerns With Preparedness

Preparedness to handle critically ill patients and mitigate risks of infectious disease spread presenting to our centers is a priority, and successful emergency preparedness relies heavily on logistic and operational aspects of implementation. For example, it is critical that proper supplies are continuously available and functional in each UC center. This can prove to be a challenge, especially when facing supply chain issues. Additionally, plans for real-time staffing adjustments in times of emergencies may be necessary as well.

Outlining how communication should function between in-center staff members, organizational leadership, and emergency services before a critical situation occurs is a key component to emergency preparedness. Such communication plans must be as specific as possible and include criteria for when EMS should be activated as well as how each team member and organizational leader should respond to limit disruptions to daily workflows and the care of other patients in the centers. Our GoPrepare has made these plans available and accessible to team members in each center. Additionally, successful communication includes establishing relationships with local health entities, such as direct lines to local EMS to facilitate ED transfers when needed. Creating emergency-specific channels within organizations

can be useful in allocating resources to the primary need. For example, part of our GoPrepare program involves the use of an "emergency only" channel within our device chat function, which we use to signal when there is a need for any available team members to assist in a crisis situation.

Establishing the Standard in Preparedness

In 2016, the Centers for Medicare and Medicaid Services (CMS) attempted to catalyze movements toward standardization of emergency response plans by creating requirements for facilities serving beneficiaries in federally supported health plans.[7] These standards required organizations that billed CMS to have an emergency plan. The emergency plan required policies and procedures for responding to threat of a contagious infectious disease, a communication plan for emergencies, and annual testing of these protocols. However, due to variations in accreditation and licensing from state to state, the standard to which these rules are upheld is inconsistent.

The Urgent Care Association (UCA) has incorporated emergency preparedness standards into the requirements for accreditation.[8] These include having emergency medications (eg, naloxone and epinephrine) and AEDs immediately available on site and staff that is able respond appropriately to in-center emergencies. Additionally, the UCA has included requirements for a documented emergency preparedness plan with details on how to maintain or return to providing clinic services if interrupted due to unexpected situations. Conducting and documenting annual mock code sessions has also been added to the UCA's accreditation standards.[8]

While the effort may seem vast, some simple steps can be taken in the direction of improving overall preparedness within individual institutions. In our organization, an additional layer to our approach to emergency preparedness is required Advanced Life Support/Pediatric Advanced Life Support certification for all providers and Basic Life Support for staff. This standard establishes a baseline culture of preparedness for all those working in centers and allows for a foundation from which to grow with additional training. Additionally, looking to partner with local health systems to participate in community emergency preparedness programs or training efforts can be a useful resource, particularly if an organization does not have a system of its own in place yet. Organizations that have not already done a hazard vulnerability analysis can also find resources from the Department of Health and Human Services to understand the significance of these tools and how to best utilize them.[9]

The intention of the criteria set forth by the UCA is to advance quality and patient safety in UC, however, they only apply to centers seeking UCA accreditation. While UCA accreditation is increasingly become an industry standard in the United States, it is not requisite for UC centers to operate. This creates the possibility of a two-tiered system and an unpredictable discrepancy in UC center emergency preparedness. For example, in a survey of New York UC centers, it was found that nearly 25% did not have written emergency plans in place, and those that did varied in their level of comprehensiveness.[2]

Emergencies by their very nature are difficult to predict. Well-developed and frequently reviewed emergency response plans support teams in being maximally effective when a crisis arises. While patients frequently present to UC centers with emergent conditions, there remains a frustratingly unpredictable level of preparedness between various UC centers. We hope though sharing our success with the GoPrepare program we can stimulate further sharing of best practices throughout the UC industry and raise the bar for our collective ability to handle emergencies that present in our centers. ■

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