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Breakout Session 3: Leadership Structures

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Brief Report

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Abstract

Establishing leadership and management structures for alternate care facilities (ACFs) presented governance challenges distinct from those of conventional hospital operations and were frequently shaped as much by political and inter-organizational dynamics as by clinical need. Symposium participants summarized operational lessons from leading ACFs across multiple jurisdictions and partnership models. Participants reported that effective ACFs typically mirrored hospital executive structures while operating under hybrid governance models that distributed authority, liability, and resources across multiple hospital systems and state agencies. Hospital Incident Command System (ICS) provided necessary scaffolding but was insufficient on its own; success depended on pre-existing inter-agency relationships and on credible leaders with the gravitas to mobilize resources across organizational boundaries. Persistent challenges included credentialing and electronic medical record (EMR) access delays, political directives that superseded clinical judgment, and severe interpersonal conflict that overwhelmed leadership without embedded human resources support. Recommended best practices include pre-identifying and training a cadre of ACF leaders, embedding human resources and behavioral health support within the leadership team, and clearly defining and protecting the ACF mission throughout activation and operations.

Introduction

The ACF Management Structures breakout session focused on participants' real-world experience with management structures within their alternate care facility (ACF) and with their partner hospital or healthcare system, if applicable. Participants were encouraged to discuss internal management and leadership of their ACF, including Hospital Incident Command System (ICS)-like organization, communication with leaders of the ACF, and unique considerations for the ACF when compared to the organization of their partner hospital or health system. Discussions about coordination with external partners such as the state or local public health were highlighted in the *External Partner Coordination* breakout session summary. The goal was to focus on what participants did, rather than proposing solutions and solving problems.

Facilitators used the following questions to prompt and guide participants:

- What did the management structure of your ACF look like?
  - Include specific examples (i.e., were you partnered with a health system? who was the operational lead?)
- Describe some of the successes with your management structure
  - How did you sustain these?
- Describe some of the challenges with your management structure
  - How were these addressed?
- Do you have any best practice recommendations for ACF management structures?

To encourage further detailed discussions, additional questions were available for facilitators:

- Did the leaders rotate on a regular basis?
  - How was this managed? Were there any issues with continuity with this?
- How was the ACF integrated into the hospital's incident command system (i.e., ICS)?
- Who provided the clinical oversight?
- What leadership positions were assigned/created for the ACF?
- How did those link to the partner hospital/healthcare system?

Theme 1: What Was Done

- **Mirroring Hospital Administration Structures:** Management structures generally replicated hospital executive arrangements, with most ACFs operating under a core leadership team modeled on a hospital C-suite (typically a Chief Medical Officer [CMO], Chief Nursing Officer [CNO], and senior operations administrator). The intent was to provide a familiar

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framework that clinical and operational staff could readily integrate into during a high-stress activation.

- **Hybrid and Shared Governance Models:** Several sites adopted shared-responsibility governance that distributed authority across multiple hospital systems and state agencies rather than concentrating it under a single institution. In one example, the highest level of management comprised a Hybrid Executive Board (i.e., hospital presidents from different facilities and the State Health Secretary), which legitimized the ACF under a state hospital framework while preserving clinical oversight by medical leaders. Participants noted that single-system control risked political imbalance and resource hoarding, whereas shared models encouraged buy-in and reciprocal resource sharing across partners.
- **Cooperative ICS Adaptation:** Most sites used an ICS framework to manage the ACF but typically established a dedicated incident command for the ACF that operated alongside—rather than nested within—partner hospital command structures. ACF-specific mission statements, objectives, and Incident Action Plans were developed to reflect operational realities distinct from the partner hospital, including patient placement and transfer, crisis standards of care decision-making, and finance functions where billing was required.
- ***Ad Hoc* Role Assignment Under Surge Conditions:** Leadership selection was frequently constrained by who was available rather than who was best matched to the role. Examples included a neonatal intensive care unit (NICU) registered nurse stepping into a CNO-equivalent position because the NICU was not surging in the same way the ICU was. Participants emphasized that staff entering an ACF leadership structure had to be aware that the operational environment would not match a conventional hospital, and that some personnel would thrive under those conditions while others would not.

Theme 2: Success and Sustainment

- **Functional Delegation and Hospital Connectivity:** Day-to-day operations were managed by a core leadership team (CMO, CNO, and lead administrator) who had delegated authority to draw resources from partner hospital systems. Effective ACFs maintained direct extensions of hospital support services into the ACF—including human resources, electronic medical records (EMRs) and information technology, biomedical engineering, pharmacy, security, environmental services, translation services, and behavioral health response—rather than attempting to recreate those functions *de novo.*
- **Credible Leadership and Disposition:** Management quality depended heavily on identifying established, credible leaders (often former military or senior hospital administrators) with the gravitas to command respect and mobilize resources across partner systems without provoking internal conflict. Beyond credentials, participants emphasized that successful ACF leaders shared a particular disposition—solutions-oriented, adaptable, transparent about constraints, and willing to listen and acknowledge problems even when unable to immediately resolve them.
- **Trust as Operational Infrastructure:** While ICS provided necessary scaffolding, ACF management effectiveness depended on pre-existing inter-agency relationships and collaboration between hospital systems, local public health agencies, and state government entities. Where leaders had deep prior connectivity, requests for resources or personnel could be made and fulfilled rapidly through informal channels; where those relationships were absent, formal authority alone proved insufficient to sustain operations.
- **Redundant Communication Channels:** Successful sites instituted multiple, overlapping communication methods to overcome the inherent challenges of inter-agency coordination (e.g., daily 10–15 minute phone briefings for leadership, a weekly "medical directors' chapter" conference call for clinical updates across all ACFs). Layered channels prevented critical information from being lost between operational periods and supported real-time staffing and resource sharing across ACFs and partner hospitals.
- **Just-in-Time Training and Specialized Branches:** Just-in-time training was used to onboard staff into incident command roles, EMR workflows, and crisis standards of care procedures. Some sites established specialized supporting branches to address ACF-specific demands, including patient placement and transfer, an ethics or crisis standards of care committee, a wellness officer for staff resilience, and an information or intelligence function to filter accurate data and counter misinformation.

Theme 3: Challenges and Mitigation Efforts

- **Credentialing and EMR Access Delays:** ACF managers encountered persistent delays in obtaining clinical credentialing and EMR access for deployed staff, which slowed activation and complicated day-to-day management. Information technology integration with the partner hospital's EMR was reported as one of the largest single contributors to delayed buildout and patient throughput, particularly for ACFs sited in non-medical buildings such as convention centers.
- **External Bureaucracy and Political Directives:** Political directives and bureaucratic barriers frequently superseded clinical judgment. Participants described instances in which clinically supported risk-stratification approaches were prohibited for political reasons (e.g., the use of age and race as inputs to triage or treatment allocation, despite supporting outcomes data, was disallowed in at least one jurisdiction), and in which decisions about ACF activation, partner hospital assignment, and operational scope were made or reversed by parties without operational expertise. State certificate-of-need rules and competition between hospital systems further complicated the identification of a willing lead clinical partner.
- **Liability, Billing, and Multi-Party Risk Allocation:** Identifying a hospital partner willing to extend its medical license over an ACF was a recurring obstacle, and questions of liability, malpractice coverage, and billing arrangements were frequent non-starters during planning. Participants noted that liability allocation became more complex when staff were drawn from multiple systems, and that resolution often depended on the perceived urgency of the disaster and on pre-existing inter-system relationships rather than on any standard framework.
- **Unmitigated Interpersonal Conflict:** The high-stress environment exacerbated severe interpersonal conflicts, including documented incidents of lateral violence and friction among multidisciplinary staff (e.g., disputes over scope of practice between disciplines unaccustomed to working in close proximity, and verbal altercations escalating during shift handoffs). Leaders were often unprepared to mediate these conflicts in the

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absence of embedded human resources support, and the absence of routine HR pathways within the ACF leadership structure meant that conflicts were frequently allowed to escalate before being addressed.

- **Temporal Dynamics of Disaster:** The temporal characteristics of the precipitating event materially influenced governance. No-notice events—such as the period following September 11, 2001—tended to compress political differences and accelerate inter-system collaboration, whereas slow-rolling events such as the COVID-19 pandemic exposed competing market interests and prolonged political contestation that complicated unified governance.

Theme 4: Potential Future Directions

- **Pre-Identified ACF Leadership Cadre:** Formalize a process for identifying, training, and certifying a cadre of credible ACF leaders prior to activation, including standardized role descriptions, written skill-set criteria, and incident command training (e.g., ICS-100 and equivalent foundational courses) for healthcare staff likely to be deployed into command roles. The intent is to ensure that ACF leadership is immediately available rather than assembled *ad hoc* under disaster conditions.
- **Mission Clarification and Protection:** Define the mission of the ACF clearly and early in activation, and protect that definition throughout operations against scope creep and shifting external directives. A clearly articulated mission supports unified objective-setting across multiple partner organizations and provides leadership with defensible boundaries when negotiating with political and regulatory stakeholders.
- **Embedded Human Resources and Behavioral Health:** Develop pre-activation plans to immediately deploy and integrate human resources and behavioral health personnel as essential components of the ACF leadership team. Embedding these functions within the leadership structure—rather than treating them as external services—provides routine pathways for conflict resolution and supports staff resilience during sustained operations.
- **Shared-Responsibility Governance Templates:** Develop flexible, generic management structure templates that anticipate shared responsibility across multiple hospital systems and state agencies, with pre-negotiated agreements covering credentialing, EMR access, liability, and resource sharing. Building these templates into routine emergency preparedness exercises—requiring participants to physically construct an ACF leadership structure and identify named individuals for key roles—tests assumptions before they are tested by an actual disaster.

Summary

Establishing leadership and management structures for ACFs required complex, multi-layered coordination between hospital systems, state agencies, and local government entities. Symposium participants emphasized that effective ACFs typically mirrored hospital executive structures while operating under hybrid governance models that distributed authority, liability, and resources across organizations rather than concentrating them under a single institution. Success required ICS frameworks paired with pre-existing inter-agency trust and leaders with the gravitas to navigate political and operational tensions. While these structures were temporary by design, effective ACF leadership prioritized clear mission definition, embedded human resources and behavioral health support, and protection of clinical decision-making against external bureaucratic pressure.

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