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# Alternate Care Facilities Symposium—Breakout Session 6: Site Selection

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**Brief Report**

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## Abstract

The use of alternate care facilities (ACFs) is an often-considered mechanism to increase care capacity during a patient surge event; however, robust guidance on appropriate site selection is limited. During the *Alternate Care Facilities Symposium*, we conducted a facilitated breakout session with participants to explore their experience in selecting ACF sites during prior emergencies. This was done to determine best practices regarding the site selection process, as well as successes, challenges, and lessons learned. Participants reported that site feasibility was primarily driven by pre-existing infrastructure, regulatory constraints, and operational factors rather than physical size or political mandate. Large congregate spaces and decommissioned hospitals frequently proved unsuitable, while successful sites were typically non-congregate, located near partner hospitals, and able to support patient dignity, safety, and privacy. Political pressures often resulted in facilities that were underutilized or operationally constrained, while infrastructure deficiencies created major barriers. Given that site selection is a critical determinant of ACF success, early multidisciplinary assessments, realistic capacity planning, and pre-activation walk-throughs and training exercises may improve future emergency response preparedness.

## Introduction

The Site Selection Breakout Session focused on participants' real-world experience with selecting a physical site for their alternate care facility (ACF). Participants were encouraged to discuss considerations including geographic location, proximity to a hospital, access routes, and existing infrastructure. Consideration was also given to which individuals and roles were included in the decision-making process and the internal and external influencing factors that impacted their decisions. ACF Design and Construction is discussed in a separate breakout session summary. The overall goal of the session was to focus on what participants experienced, rather than proposing solutions to historical or anticipated future problems.

Facilitators used the following questions to prompt and guide participants:

- What were your approaches to site selection for your ACF?
  - Include specific examples, proximity to partnering hospitals, building type, etc.
- Describe some of the successes with your site selection processes.
  - How were these sustained over time?
- Describe some of the challenges with your site selection processes.
  - How were these addressed?
- Do you have any best practice recommendations for ACF site selection?

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

- Was the location selected pre-planned as part of emergency preparedness, or was it determined during the emergency?
- What criteria made a non-hospital facility appropriate to be converted into an ACF?
- What tools/resources were useful for decision-making on site selection or the best ACF model?
- Were there cultural considerations you experienced that are worth planning for, or being aware of, as it relates to site selection?

## Theme 1: What Was Done

- **Infrastructure and Regulation Determined Feasibility:** During previous emergencies, site selection decisions were often driven by political pressure or physical size of the site, but long-term feasibility was contingent on existing infrastructure (such as power, water, climate control, etc.) and regulatory approvals.

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- **Political Mandates vs. Rationality:** Decisions were often dictated by governmental leaders (i.e., "Governor just issued an order for a 2,000-bed facility") that dramatically overstated the capacity that would ultimately be needed. This often forced the construction of facilities that were underutilized over the course of the emergency.
- **Congregate Site Limitations:** Large assembly spaces (i.e., gymnasiums and fairgrounds) were largely deemed "totally inadequate" for medical care due to core logistical and utility constraints (i.e., lack of power outlets, minimal bathrooms, and poor lighting that "you could not turn off").
- **End-Date Planning and Exit Strategy:** Site selection required negotiating agreements for site closure and end-date planning to avoid financial penalties or losing access to a specific space (i.e., returning college dorms/schools to normal function).
- **Accessibility and Dignity:** The viability of a site was heavily influenced by basic sanitation and accessibility for all patients and staff, including access to adequate toilets, showers, and ramps/elevators.
- **Power and Safety Infrastructure:** Facility bed capacity was critically dependent on electrical load capacity (i.e., avoiding tripping circuit breakers due to power demands), the need for generator backup, and managing safety (i.e., monitoring smoke and carbon monoxide in tents).
- **Mission and Patient Needs Dictate Site Type:** The anticipated function and duration of service for the ACF most appropriately dictated the appropriate site, emphasizing facilities that could support non-congregate care, which also had pre-existing utilities in place. These included power outlets (generally not available in large gymnasiums), lack of accessible backup power, internet connectivity, appropriate ventilation/airflow and lighting, weather resilience, bathroom proximity and privacy, Americans with Disabilities Act (ADA) compliance, infection prevention considerations, and suitable ingress/egress routes.

## Theme 2: Success and Sustainment

- **Proximity to Hospital Services:** Site viability and utilization were strongly associated with proximity to a partner hospital to facilitate immediate and ongoing clinical support (i.e., lab and imaging) and patient/pharmaceutical/supply transfers.
- **Hotel Model for Isolation:** Hotels were considered to be an appropriate non-congregate solution for quarantine/isolation and safe medical respite, leveraging private rooms for infection prevention and control as well as patient comfort, and due to pre-existing mechanisms for providing basic services (laundry, food preparation, access, etc.).

## Theme 3: Challenges and Mitigation Efforts

- **Unsuitability of Assets:** Decommissioned hospitals were frequently non-viable due to physical degradation (i.e., "HVAC was dead," "wiring is from the 50s"). This often resulted in an engineering veto of what initially appeared to be an ideal solution.
- **Specialized Infrastructure Needs:** Non-hospital sites required specific, non-clinical conversions. Some sites were deemed viable only after experts recommended pouring a new concrete slab, installing required fire protection, and addressing infection prevention concerns, among other critical improvements.
- **Infrastructure Constraints Determined Site Feasibility:** The availability of utility connections (power, water, sewage, etc.) for a site frequently imposed non-negotiable constraints that influenced the viability of a site.

## Theme 4: Potential Future Directions

- **Pre-Utilization Walkthroughs:** ACF planning should incorporate pre-activation assessments of potential sites to identify non-negotiable physical, logistical, and safety constraints. This could be completed by a pre-identified team of personnel, which includes structural and utility engineers, clinical operations specialists, legal/regulatory counsel, emergency management, etc.
- **Workflow Simulations and Testing:** Sites should complete exercises or simulations to test clinical and logistical procedures prior to accepting patients in order to provide opportunities for re-design/mitigation workflows to ensure operational readiness.

## Summary

Site selection emerged as one of the most consequential planning decisions, with long-term operational success or failure often determined by initial site choice. Symposium participants reported that decisions were frequently driven by political mandates or the physical size of the site, rather than careful assessment of pre-existing infrastructure, logistics considerations, and patient safety, dignity, and privacy. Decommissioned hospitals and large assembly spaces, such as gymnasiums, often proved unsuitable despite appearing ideal on paper. Successful site selection required careful balancing of existing technical infrastructure, proximity to hospital services, patient needs, and political realities, as seemingly minor details frequently created major operational constraints.

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