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Breakout Session 10: Miscellaneous Topics

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Brief Report

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Abstract

This final breakout session provided subject matter experts with an opportunity to discuss additional considerations that were not previously covered during the Alternate Care Facilities (ACF) Symposium. Participants reflected on operational experiences not otherwise captured and discussed barriers, mitigation strategies, and future priorities for ACF implementation. Several recurring themes emerged. Despite significant hospital strain, many ACFs experienced underutilization due to institutional reluctance to transfer patients, financial and political considerations, limited stakeholder engagement, and patient mistrust of nontraditional care settings. Participants described successful approaches to improving operations, including staff wellness initiatives, work-rest cycles, community engagement, and communication strategies to improve patient trust. Persistent challenges included patient refusal of transfer, difficulties coordinating care and patient movement across multiple ACFs within a region, loss of institutional knowledge following staff turnover, and leadership fatigue due to limited redundancy among key operational personnel. Participants emphasized the need for regional coordination mechanisms, centralized repositories of operational lessons learned, earlier integration of nonclinical operational leaders, and deliberate communication strategies to increase trust among referring hospitals and communities. These findings suggest that successful ACF implementation depends on institutional trust, regional coordination, workforce sustainability, and preservation of operational knowledge to support future emergency response efforts.

Introduction

The Miscellaneous Topics session provided participants with an opportunity to discuss any other considerations, challenges, or successes that were not already detailed for their alternate care facility (ACF). These include topics like patient experience, patient movement, staff experience, as well as planning resource and guideline utilization and improvement plans.

This session was different from the other breakout sessions in that all participants were pulled out of their small groups and brought back together into a large group of all participants. This was the last session of the 2-day symposium.

This session was led by a facilitator who prompted the discussion using the following questions:

- Were there any topics or considerations that you feel are important that were not already discussed over the last 2 days?
  - Include specific examples
- Were there any successes that you feel are important that were not already discussed over the last 2 days?
  - How did you sustain these?
- Were there any challenges that you feel are important that were not already discussed over the last 2 days?
  - How were these addressed?
- Do you have any other best practice recommendations for ACF implementation and operations?

Theme 1: What Was Done or Experienced

- **Underutilization and Stigma around ACFs**: Many established ACFs were severely underutilized with high bed count availability but overall low patient census. This occurred despite local and surrounding hospitals being overwhelmed and remaining at or above capacity. Symposium participants noted a disconnect between ACF capabilities and hospital willingness to send patients to the ACF for care. Participants cited a number of factors that contributed to this disconnect, including financial incentives for hospitals. Hospitals were reluctant to transfer revenue-generating patients in some instances. Participants also noted

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some challenges with regional politics contributing to this reluctance with some systems not wanting to utilize ACFs stood up by competitors in the region. Additionally, contributing to hospital reluctance was the fact that some hospitals systems were not stakeholders in the ACF and so did not promote the utilization of the ACF by their clinical teams. Some patients were also reluctant to be transferred to the ACF and would refuse to be treated in the ACF due to perceived stigma or fear of novel, institutional settings like gymnasiums being utilized for care.

Theme 2: Success and Sustainment

- **Staff Wellness and Team Morale**: Participants discussed successful efforts to improve staff wellness and morale while working at the ACF. One group provided T-shirts and challenge coins to boost staff morale and cement the team's identity. Another leadership group implemented daily briefings and a mandatory time off after working for 14 days to establish a work-rest cycle for staff. Other groups awarded additional paid time off (PTO) to staff who participated in the response and worked at the ACF.
- **Community Marketing to Improve Patient Trust**: Many participants discussed efforts to market the ACF to the community to improve trust and build relationships with potential ACF patients. In one response, patients were noted to avoid the ACF that was in a tent even though the care was free of charge and the local hospital only took private insurance. This changed after a radio personality that was trusted by the community discussed the ACF and its capabilities on the air. This highlighted one success with engaging community champions for the ACF. During another response, one physician who was very involved in the community met with trusted community members and put out messages about the ACF on the radio and in social media which improved community willingness to utilize the ACF.
- **Partnerships for Transport from Hospitals to ACFs**: Participants discussed utilizing existing partnerships with academic institutions who have existing transport teams at their facilities to mitigate transportation from the hospital to the ACF. These partnerships were simply expanded to include the ACF as a transport site.
- **Early Involvement of Technology Experts**: ACFs that addressed technology concerns early noted ease of incorporation into ACF operations during activation. During the COVID-19 pandemic, this technology planning was started as early as infection rates of COVID-19 were noted to rise in the region. Technology requiring advanced planning included considerations for connectivity, especially if utilizing electronic health records (EHR) and performing laboratory or imaging diagnostics on site. Participants noted that this was a critical first step during the planning process.
- **The Value of Simple Tools**: Quick, simple data tools (i.e., tracking supplies, bed count, and patient status using shared spreadsheets or quick forms) were consistently more valuable in the initial crisis phase than in complex EMR systems that require extensive training and IT infrastructure.

Theme 3: Challenges and Mitigation Efforts

- **The Patient's Right of Refusal**: Participants noted that hospital and ACF staff could not force patients to accept care at the ACF, reinforcing the patient's right to refuse transfer. Some hospitals and ACFs experienced this challenge during operations. This could significantly limit load leveling for regional facilities and prevent the ACF from being utilized to its full capabilities to decompress hospitals. Mitigation options discussed by symposium participants included the need for a legal entity or authority, like the state, to issue mandates that support the transfer of particular patient populations from hospitals to ACFs if the situation requires, regardless of patient agreement. Participants discussed that there may come a point during a public health emergency when patients will need to be forced to go to ACFs for care.
- **Activation of Multiple ACFs in One Region**: Challenges were noted around building a network between various ACF sites and partner hospitals when multiple ACFs were stood up in a single region. This made patient placement and movement throughout the region challenging. Additionally, participants noted that the reporting of beds and resources from hospitals and ACFs in one region was often manipulated to protect individual facility resources. Mitigation discussions focused on establishing a medical operational coordination center (MOCC) to assist with regional load balancing and coordination across counties. Participants also recommended establishing a regional command and control mechanism for transfers and patient placement, which could be through the MOCC. Other discussions focused on designated specialized care to specific ACFs in the region to improve coordination of care.
- **Institutional Memory Loss**: High staff turnover in the years following a crisis led to a profound loss of institutional knowledge, forcing the next generation of responders to relearn critical operational and policy lessons like how to secure a specific waiver or how to run a courier system.
- **Leadership Depth as a Single Point of Failure**: Sustained ACF function was persistently challenged by the lack of "people redundancy." Key leaders become the "single point of failure," unable to delegate or take adequate respite due to the complexity of their unique roles, necessitating the rapid development of Just-in-Time Training and "people redundancy" planning.

Theme 4: Potential Future Directions

- **The Need for a Universal Data Repository**: A major gap exists in accessing and utilizing operational data. A central repository is needed to archive after-action reviews, successful protocols, and performance metrics (i.e., bounce-back rates) to provide accessible guidance for future ACF activations.
- **Mandatory Respite**: To combat fatigue and moral injury, management should enforce mandatory time off and institutionalize staff wellness programs (i.e., providing mental health check-ins, access to supportive care, and dedicated respite spaces for decompression). This should include work-rest cycles for all staff and providers.
- **Involve Non-Clinical Leadership in the Early Planning Process**: Participants noted the importance of involving leaders from security, case management, facilities, and IT in initial planning meetings. These leaders or representatives should be incorporated into the ACF leadership structure throughout the ACF operational period.
- **Marketing to Hospitals and Clinical Teams:** There was noted distrust of some sending clinical teams who did not want to "send patients where they will be on a cot." Participants recommended deliberate marketing and communication to hospitals and sending provider teams to establish confidence in the facility's capabilities. This could be done through websites,

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brochures, and capability slide decks shared with hospitals and clinical teams to improve comfort in sending appropriate patients.

Summary

This section was used to address any topics not covered during the workshop, including broader system-level issues affecting ACF utilization, sustainability, and institutional learning. Symposium participants documented significant underutilization of ACFs despite hospital strain, driven by institutional reluctance to transfer patients and public stigma. Leadership burnout emerged as a critical sustainability threat, with key personnel becoming single points of failure. The absence of centralized data repositories and regional coordination frameworks means that hard-won lessons are repeatedly lost, forcing each new crisis response to relearn operational fundamentals. Moving forward, a universal repository of resources should be established for shared after-action reports and successful protocols. Capability information and marketing should target sending clinical teams and hospitals, and non-clinical but essential personnel like IT and facilities should be involved in the initial ACF planning and remain incorporated into the leadership structure for the ACF operations.

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