Disaster Medicine and Public Health Preparedness

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Breakout Session 4: Clinical Operations

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Brief Report

Cite this article: Vandeford N, Little C, Huffman E and Herron AK (2026). Breakout Session 4: Clinical Operations. *Disaster Medicine and Public Health Preparedness*, **20**, e205, 1–3
https://doi.org/10.1017/dmp.2026.10421

Received: 13 March 2026 UTC
Revised: 13 May 2026 UTC
Accepted: 27 May 2026 UTC

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Abstract

Alternate care facilities (ACFs) established during disaster response operations are required to deliver safe clinical care under severe operational, staffing, and infrastructure constraints. This breakout session explored real-world experiences managing clinical operations within ACFs, emphasizing lessons learned from frontline leaders responsible for patient flow, escalation of care, documentation, discharge planning, and support services. Participants described highly adaptive workflows shaped by limited laboratory, radiology, pharmacy, and electronic health record capabilities. Many sites relied on simplified triage models, selective laboratory testing, courier-based diagnostics, and external vendor partnerships to sustain operations. Clinical success was associated with integration of social work, discharge planning, culturally responsive care, and management of vulnerable populations, including patients with behavioral health and substance use disorders. Participants identified significant challenges related to fragmented medical records, EHR downtime, staffing fatigue, language barriers, and inability to replicate hospital-level ancillary services. Key recommendations included embedding social support services early in operational planning, standardizing workflows, developing culturally informed liaison infrastructure, and strengthening backup documentation training. Findings highlight that effective ACF clinical operations depend not only on medical capability, but also on flexible systems supporting communication, discharge coordination, and continuity of care during disaster conditions.

Introduction

The Clinical Operations breakout session focused on participants' real-world experiences managing clinical operations within their alternate care facilities (ACFs). Discussions covered all aspects of patient care, from admission workflows to escalation of care to transfer and disposition. Participants were also encouraged to share insights regarding documentation processes and patient safety. The goal was to describe what was *actually done*, rather than proposing solutions and solving problems.
Facilitators used the following questions to guide discussion:

- What did clinical operations look like at your ACF?
- Include specific examples (i.e., was radiology available? Were labs run onsite or sent out? etc.)
- Describe some of the successes with your clinical operations.
- How did you sustain these?
- Describe some of the challenges with your clinical operations.
- How were these addressed?
- Do you have any best practice recommendations for ACF clinical operations?

To prompt detailed discussions, additional questions were available for facilitators:

- What types of support services were on site (e.g., pharmacy, labs, radiology, respiratory, PT, OT, speech, etc.)
- What types of support services were available in proximity to the ACF?
- What system was used for patient care documentation (EHR, paper, hybrid)?
- What was the typical patient flow from admission to discharge in this setting?
- What protocols were in place if a patient deteriorated?
- What emergency equipment and medications were on hand?
- How was transport for patients managed (e.g., back to the hospital or imaging)?
- What discharge protocols were in place? Was patient recovery improved by discharge support and did the support reduce re-entry into the health care system?
- Are there patient cultural considerations you have experienced that are worth planning for or being aware of as it relates to clinical care?
    - Were there patient and/or family language and/or communication challenges you experienced? What were those challenges? How did you handle that?

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- Were there patient support considerations (e.g., planning to have family/visitors) that you experienced?

Were there access and functional needs considerations you experienced that you wish you had considered planning for?

Theme 1: What Was Done

- **Limited Laboratory and Radiology Services:** Most sites operated with significant limitations: "No blood bank, Computerized Tomography (CT) [Scanner], or advanced compounding on-site." Lab work was restricted to tests that "would change management," often requiring a single daily courier service to the partner hospital. For example, blood cultures might be drawn if there was a concern for sepsis, but daily labs (CBC and BMP) that might be standard in the hospital used to track subtle changes were not drawn due to logistic and operational challenges of adequate staff to draw labs, running labs in-house or couriering to a larger facility, and provider bandwidth.
- **Essential Pharmacy Services:** Pharmacy support was critical for pain control and chronic disease management. This required sophisticated logistics and strong agreements with commercial partners (i.e., CVS and Walgreens) to handle controlled substances and specialized dispensing.
- **Cultural and Communication Challenges:** Widespread language and cultural barriers required the use of technology (i.e., translation tablets) and community liaisons to bridge the communication gap for diverse patient populations with varying dialects and special dietary needs (religious and medical).
- **Patient Safety Risk From High-Acuity Admissions:** Expanding admission criteria, often driven by political pressure and systemic necessity, led some ACFs to accept increasingly acute patients. This created safety risks, illustrated by an incident where "one of the ER Docs tried to put a chest tube in a patient" in a facility structurally incapable of supporting such interventions. The facility could not support a higher level of care or acuity due to a lack of acute care providers and appropriately trained staff. Although the provider had the ability to perform the procedure, the ACF did not have the ability to support a patient following a higher acuity procedure.
- **Political Undermining of Expert Planning:** Clinical consensus decisions made by experts were sometimes overridden or altered by political leadership. This resulted in staff occasionally learning about critical, unvetted changes by "watching the news," forcing local facilities into reactive rather than proactive planning for clinical operations.
- **Political Support for Clinical Autonomy:** In contrast, some clinical leaders were given "a lot of freedom" and "independent management structure," with political leadership deferring to their expertise and committing not to "change up what we were doing," a crucial factor in maintaining provider confidence and continuity of care.

Theme 2: Success and Sustainment

- **Integrating Flow, Discharge, and Social Support:** Successful clinical operations extended beyond the patient's medical condition to address the significant social and logistical needs of disaster-affected populations. For example, accommodations were made to support the need of patients to see or speak with their families and have meals that were culturally appropriate.
- **Managing Vulnerable Populations:** The admission of patients with substance use disorders and mental health needs required innovative on-site safety measures (i.e., designated smoking areas and medical monitoring near high-risk areas) and staff skilled in addiction medicine and social work.
- **Sustained Individualized Supportive Care:** Despite logistical hurdles, some ACFs achieved genuine success in stabilization of chronic diseases, providing tailored supportive care. Examples included providing dedicated efforts to address diabetes education for historically underserved patients who often received less individualized attention in hospital settings.

Theme 3: Challenges and Mitigation Efforts

- **Downtime and Training Deficits:** Staff unfamiliar with paper charting struggled during EHR downtimes, creating continuity of care challenges and highlighting the need for training in backup documentation methods.
- **Patient Tracking Gaps:** Tracking patients who were transferred or discharged was difficult without electronic systems integration. Systems like E-Finds were activated to help staff locate patients who had been moved across the region, demonstrating the need for regional solutions.
- **Fragmented Medical Records:** Inconsistent access to integrated medical records posed significant barriers to safe, continuous patient care, demanding creative, non-traditional solutions.
- **Limits in Replicating Hospital-Level Support:** ACFs struggled to replicate complex hospital support functions, forcing a reliance on rapid clinical triage to limit patient complexity and leveraging external vendor partnerships.
- **Triage-Driven Exclusion Criteria:** The absence of on-site services like dialysis or advanced monitoring meant that patients requiring these services were automatically excluded and sent back to acute care, often needing full re-registration as a new patient.
- **Discharge Planning as an Outflow Barrier:** Discharge planning was complicated by the patient's social status (i.e., housing instability) and the disruption of the post-acute network (i.e., lost nursing home beds), requiring ACF staff to effectively act as case managers.
- **Burnout and PPE Requirements:** ACF's that were set up during the COVID pandemic noted that the necessity of wearing full personal protective equipment (PPE) required implementing mandatory short shifts (i.e., three-hour rotations in full PPE) and enforced time off to mitigate provider burnout and dehydration.
- **EHR Integration Complexity:** While some ACFs achieved a pared-down electronic system (i.e., Epic extension or a bespoke REDCap tool), the simplest solution remained paper charting, especially for offsite or non-hospital-affiliated facilities.

Theme 4: Potential Future Directions

- **Early Implementation of Social Work and Discharge Procedures:** In ACF plans, embed social work and case management personnel into staffing plans and pre-establish contacts with post-acute care networks to support discharge procedures.
- **Cultural Liaison Infrastructure:** Consider pre-identifying cultural liaisons who are familiar with diverse local cultures,

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dialects, and religions to assist in ACF medical interpretations. This moves beyond relying on tablets alone and provides a sustainable solution for cultural and communication challenges.
- **Standardized Workflow Development:** Creating consistent workflows for key functions, such as patient intake and discharge planning, could strengthen operational readiness.

Summary

Clinical operations within ACFs focused on delivering safe, simplified care under significant resource constraints. Participants described constant adaptation of workflows to accommodate limited ancillary services, documentation challenges, and complex patient populations with significant social needs. Without traditional hospital support systems, such as laboratory, imaging, pharmacy, and integrated electronic records, staff relied on creative problem-solving and careful triage to ensure patient safety. Successful sites emphasized that ACF operations must extend far beyond medical treatment to encompass case management, social work, and discharge planning for vulnerable populations.

Author contribution. Natasha Vandeford: Final draft, full review; Charlie Little: Final draft, full review; Amy Herron: Initial summary of information and raw data; Elaina Huffman: Initial summary of information and raw data.

Competing interests. None.

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