Alternate care sites (ACS) can help to alleviate health system stress caused by COVID-19 patient surge events. The following resources and documents are intended to support state, tribal, local, and territorial (STLT) governments in the establishment and operation of an ACS.

In addition to an ACS, a comprehensive healthcare response to COVID-19 surge events at the state or local level should incorporate an entity responsible for maintaining situational awareness and coordination of hospital capacity, resource needs, and patient transfers (e.g., a Medical Operations Coordination Cell). ACS planning and operations must also take into account the need to ensure accessibility for patients with disabilities and with limited English proficiency.

Guidance Documents

Alternate Care Site Toolkit, 3rd edition (HRWG) The ACS Toolkit is medical operations guidance and was developed with the intent to help STLT entities address potential capacity and capability gaps in health care systems during the COVID-19 pandemic. It provides guidance and technical assistance to STLT entities in establishing and operationalizing an ACS for COVID-19-positive patients, presumed COVID-19-positive patients, and/or non-COVID-19 patients in a mixed setting. The Toolkit includes both a Key Takeaways section and an ACS startup checklist.

Medical Operations Coordination Cell (MOCC) Toolkit (HRWG) The MOCC Toolkit offers flexible and modifiable guidance, aimed to assist regional, STLT governments to ensure load-balancing across healthcare facilities and systems.

ASPR TRACIE Topic Collection: COVID-19 Alternate Care Site Resources (ASPR) This Topic Collection focuses on plans, tools, templates, and other immediately implementable resources to help with COVID-19 preparedness, response, recovery, and mitigation efforts, focusing on the establishment and operation of Alternate Care Sites.

Infection Prevention and Control Considerations for Alternate Care Sites (CDC) This guidance provides critical infection prevention and control considerations for ACS and is intended to supplement existing plans.

ACS Implementation Support Materials (USACE) These materials were developed by medical and construction experts from the U.S. Army Corps of Engineers (USACE) and the U.S. Department of Health and Human Services to help address potential shortages in medical facilities during the COVID-19 pandemic. They are intended to assist in assessing and developing potential facilities for suitability as ACS and to rapidly engage contractors to convert and prepare them for medical use.

CMS Programs and Payment for Care in Hospital ACS (CMS) This document provides state and local governments developing ACS with information on how to seek payments through CMS programs – Medicare, Medicaid, and the Children’s Health Insurance Program – for acute inpatient and outpatient care furnished at the site.

COVID-19 and ACS – Implementation Examples

Using a Fairgrounds for Surge (video slides) (Project ECHO COVID-19 Clinical Rounds)

This document contains weblinks and references to non-Federal websites, articles, and webpages, marked with an asterisk (*). Linking to a non-Federal website, author, or article does not constitute an endorsement by the U.S. government of the information and/or products presented on that site or resource.
Ben Weston, MD, MPH, provides an overview of the establishment and operation of an ACS at the Wisconsin State Fairgrounds.

Critical Considerations
- Prioritize the formation of an executive leadership team.
- The WI ACS was designed, staffed, and equipped to care for lower-acuity patients.
  - Initial admission criteria – 18-70 years old; ambulatory; 24 hour of stable vital signs; can be on supplementary oxygen; can be receiving IV fluids (for hydration vs. med infusion); low need overall.
  - Admission criteria should be flexible enough to change as community’s needs change.
- Consider interior space, parking, security, proximity to local hospitals, and infrastructural supports (e.g. power supply, internet, cell phone coverage & access during site selection.
- Request that sending facilities include a three day supply of patient medications
- The decision to establish an ACS should be guided by available resources, and analysis of local, regional, and state-wide trends, and the input of clinical and operational experts.
- Before considering an ACS, maximize the number of available hospital beds; the number of hospital beds that can be converted; and the number of hospital beds that can be set up in non-patient care spaces.
- Triggers and Thresholds
  - WI categorizes hospital surge capacity into three phases:
    - Phase I – routine acute care and ICU bed capacity
    - Phase II – use of current clinical space to expand either acute care or ICU bed capacity
    - Phase III – use of space not typically used for acute care or critical care
  - The trigger for starting to move from one phase to another is when 70- 75% occupancy has been reached. (A 70% threshold would be for smaller hospitals, 75% for larger community and tertiary hospitals.)
  - Hospitals in WI would transfer patients to the Fairgrounds ACS if their capacity is approximately 70% -75% of the Phase II capacity and are considering transitioning to Phase III. However, all hospitals have agreed to maximize the use of their healthcare system’s Phase II capacity prior to utilizing the ACS.

Building a COVID-19 Hospital (video UM slides LSU slides) (Project ECHO COVID-19 Clinical Rounds) Melissa Brunsvold, MD, and Meghan Maslanka, MD, described the establishment and operations of ACSs at the University of Minnesota and New Orleans’ Ernest N. Morial Convention Center, respectively.

Alternative Care Sites for the Covid-19 Pandemic: The Early U.S. and U.K. Experience* (New England Journal of Medicine) ACSs provide essential capacity to cope with the demands of the Covid-19 pandemic. There are several different approaches and each can be effective depending on the specific needs of a particular location. Early experience with these facilities in the U.S. and the U.K. have yielded valuable lessons about how to structure and operate them most effectively, and about how to integrate them with overall health care services in a region.

Critical Considerations
- Match local needs to ACS capabilities and capacity.
- Build a relationship between the ACS and existing acute care hospitals.
- Be explicit about the ACS’s mission and its admission criteria.
Creating COVID-19 alternate care site trainings for interprofessional teams* (Public Health Nursing) This case study of the Colorado experience developing training for community-based COVID-19 care delivery sites can inform other public health planners creating the same in their locales.

Development of a COVID-19 alternate care site from ground zero: A nursing perspective* (Public Health Nursing) Describes the rapid development of a hospital care model ACS to care for mild to moderately symptomatic COVID-19 patients in Memphis, Tennessee. Includes an ACS nursing checklist.

The Federal Experience in New York City (ASPR) Describes the establishment and operation of an ACS at the Jacob K. Javits Convention Center.

Critical Considerations
- A central nurse call bell system and a central vital sign monitoring system enabled remote patient monitoring.
- The lack of an electronic health record was a critical gap.
- Consider having designated staff monitor and assist with personal protective equipment donning and doffing.

Deployment of a Shared Alternative Care Site During the COVID-19 Pandemic* (JEMS) Describes the establishment of an ACS at the Greater Columbus Convention Center.

Critical Considerations
- The decision to establish an ACS was made by hospital executives and supported by local public health authorities.
- A leadership team was formed, and included hospital executives, the Central Ohio Trauma System, the Ohio National Guard, the site coordinator, and local emergency management.
- Includes costs associated with ACS stand-up and stand-down.

For additional information, contact: COVID-Healthcare-RFI@hhs.gov.