STRATEGIES FOR EFFECTIVE ALTERNATE CARE SITES IN RURAL IOWA

By: Lynn J. Royer

Abstract

Rural communities face unique healthcare access challenges during disasters, often compounded by geographic isolation, limited healthcare infrastructure, and healthcare systems that quickly become overwhelmed. These challenges can exacerbate health disparities, leaving rural residents vulnerable to adverse health outcomes during emergencies. Ensuring access to medical services in these areas is key for healthcare facilities. Alternate care sites are crucial in providing care when traditional healthcare facilities are overwhelmed or inaccessible. The purpose of this article is to propose alternate care site strategies that enhance preparedness and response efforts to ensure equitable access to care in rural Iowa communities during a disaster.

This study was conducted through a review of existing literature, an analysis of current practices, and with expert insights to highlight the importance of collaboration, flexibility, and innovation in disaster preparedness. The study concludes that an effective disaster response in rural Iowa requires cross-sector collaboration, adaptable planning, and innovative approaches to ensure resilient healthcare systems during disasters.

Overview

In rural communities, where healthcare access can be limited, disasters can drastically disrupt access to essential healthcare services. Establishing an alternate care site is vital for ensuring that residents receive necessary medical attention when traditional facilities are overwhelmed or inaccessible.

This paper is particularly relevant given that events in rural Iowa have impacted local hospitals in rural communities over the past two decades. Notable disasters include the 2018 Marshalltown Tornado, the COVID-19 pandemic, the 2020 Midwest Derecho, the 2024 Greenfield Tornado, the 2006 Cedar Rapids floods, and the 2024 Northwest Iowa floods. These natural disasters and public health emergencies have demonstrated the need for effective alternate care site strategies tailored to the needs of rural communities. These events have exposed gaps in preparedness and response while also driving positive developments, underscoring the need for localized strategies that address the challenges faced by rural communities.

The purpose of this article is to propose alternate care site strategies that enhance preparedness and response efforts to ensure equitable access to care in rural Iowa communities during a disaster, and to explore practical strategies to enhance the implementation of alternate care sites in rural Iowa communities. To accomplish this, a multi-faceted approach was used, incorporating various strategies to address the unique challenges of rural healthcare preparedness and response. The study begins with a literature review of existing research on alternate care sites. Second, a survey of hospital and county emergency managers in rural Iowa was conducted to determine current capabilities and perspectives on overall readiness. The survey results helped shape the third strategy, which involved interviews with hospital emergency managers to better understand

the challenges and opportunities in establishing effective alternate care sites. This article then delves into the results and findings of this research, concluding with key lessons learned, outlining strategies for strengthening rural alternative care site planning and response, and summarizing the overall takeaways.

Methodology

The methodology used to understand the scope and context of the issue in this paper was completed in three phases. Phase one involved a literature review of articles on alternate care sites, providing a foundational understanding of their definition, role, and the challenges of healthcare access in rural communities during disasters. The articles were selected for their relevance to rural healthcare, their focus on the role of alternate care sites in disaster response, and practical strategies for improving care for vulnerable and underserved populations. This phase focused on gathering and analyzing existing research, highlighting successful strategies and barriers, and helping shape the subsequent phases of the study. Two challenges were encountered during the literature review. One was the limited availability of relevant literature on alternate care sites in rural contexts, and the lack of a standard definition of an alternate care site.

Phase two included a survey targeting hospital and county emergency managers in Iowa to assess their perspectives on current capabilities, challenges, and readiness related to alternate care site implementation in rural areas. The survey gathered quantitative data on existing collaboration, perceived gaps in disaster response, and local preferences for care delivery models. It was distributed using contact information from Iowa Healthcare Coalition Coordinators and the Iowa Emergency Management Association district contact lists. One challenge encountered in conducting the survey was ensuring a high response rate, as participation depended on the availability and engagement of emergency managers. To increase participation, follow-up electronic communications were sent to encourage participation and maximize the response rate.

The results from phase two helped guide the third phase of the study. The interviews aimed to dive deeper into the operational challenges, successes, and gaps in disaster response based on the survey findings. Interviewees were selected based on their involvement in planning, activating, and managing alternate care sites during disasters, with a focus on those who could provide a range of perspectives on the challenges and best practices in rural disaster response. This selection approach aimed to capture insights from a variety of rural communities across Iowa with different geographic and demographic characteristics. The interviews explored each participant's experiences with planning and activation, the successes and challenges they faced, and their recommendations for improving alternate care site strategies. The semi-structured interview format allowed participants to share unique insights while still addressing key topics. Interviews were conducted virtually and electronically, with participants' consent.

Results and Findings

The existing literature highlights the role of alternate care sites in addressing healthcare needs during disasters, particularly in rural and underserved areas. These sites serve as extensions of healthcare systems, providing additional capacity when hospitals and clinics are overwhelmed or inaccessible. Alternate care sites are particularly crucial in areas where access to medical facilities is strained under normal conditions. The Administration for Strategic Preparedness and Response (ASPR) (2024) stresses that well-planned alternate care sites can mitigate the impact of disasters by ensuring timely care for vulnerable populations, reducing the burden on traditional healthcare facilities, and contributing to coordinated disaster response. However, to implement these sites effectively, several challenges must be addressed, including resource allocation, logistical coordination, and ensuring that healthcare services are coordinated across different levels of the healthcare system.

In a study by Meslanka et al. (2021), the role of alternative care sites during the COVID-19 pandemic was examined, highlighting the need to adapt these sites to changing circumstances. Their research emphasized the importance of scalability and adaptability in the design of alternate care sites to accommodate fluctuating demand. Similarly, Wang et al. (2021) explored the implementation of alternate care sites for individuals experiencing homelessness during the COVID-19 pandemic. Their research highlighted that low-barrier, collaborative interventions and innovative models, such as combining onsite healthcare with telehealth services, were successful in maintaining quality care without sacrificing accessibility for this vulnerable population. Davis et al. (2011), in their research on alternate care site planning in rural settings, noted that research shows poor and medically underserved populations, particularly in rural areas, are disproportionately affected by disasters. The study found that 46% of evacuees in West Virginia following Hurricane Katrina had at least one chronic medical condition. The research pointed out that these chronic conditions can worsen quickly in a disaster, leading to higher mortality rates among vulnerable populations. The authors determined that the management of chronic diseases and the provision of necessary medical equipment are often neglected in disaster planning, further exacerbating health disparities in these communities.

The Centers for Medicare & Medicaid Services (CMS) defines an alternate care site as “Any building or structure that is temporarily converted or newly erected for healthcare use, serving as an extension of a healthcare facility during a public health emergency.” (CMS, 2020) The ASPR defines alternate care sites as locations converted to provide inpatient and/or outpatient healthcare services when a hazard impacts existing facilities or when the volume of patients exceeds available capacity and/or capabilities. Additionally, ASPR includes shelter medical care as part of their alternate care sites (ASPR, 2020). Bell et al. (2021) states that alternate care sites are sometimes referred to as “field hospitals,” which adds another layer of meaning, often evoking a military connotation. These varied definitions demonstrate the flexibility of alternate care sites, which can be adapted to meet the needs of different disasters and healthcare systems. However, this diversity in definitions can also create challenges when comparing strategies and outcomes across studies. It underscores the importance of research that is tailored to different

settings, especially in rural areas. The literature review concluded that the establishment of alternate care sites is crucial in maintaining healthcare access during disasters, particularly in ensuring continued access to healthcare for vulnerable populations.

However, the literature review revealed limitations. While the concept of alternate care sites has been part of disaster planning for many years, the most recent literature focuses on implementation and challenges during the COVID-19 pandemic. This focus limits broader insights into alternate care site strategies beyond the pandemic context. Additionally, the existing studies were often conducted in various regions of the United States, which may not fully reflect the unique challenges of rural Iowa, where geographic isolation, limited healthcare infrastructure, and smaller populations require tailored approaches.

A survey of 27 Iowa healthcare and county emergency managers, representing counties with diverse populations, revealed mixed preparedness levels. The survey was conducted between October 2024 and January 2025. Participants included 18 hospital emergency managers and nine county emergency managers from Iowa. Participants represented counties with populations ranging from 7,005 (Ida County, Iowa) to 152,854 (Johnson County, Iowa) (US Census Bureau, 2020). The 22% response rate among 123 potential participants highlights the difficulty of engaging rural emergency managers.

The survey found that 37% of participants felt prepared to establish an alternate care site, while 29.6% felt unprepared. Key challenges identified included funding constraints, staffing shortages, and communication gaps. One participant noted, “Without funding and buy-in from administrators and government officials, it’s difficult to allocate time and resources [toward alternate care site planning].” The survey findings suggest that while some rural Iowa counties have made strides in planning for alternate care sites, there are gaps in preparedness, primarily due to resource limitations.

As noted in the literature review, vulnerable populations, such as the elderly, low-income individuals, and those with disabilities, were recognized as particularly susceptible to facing barriers to access during a disaster. Survey respondents also recognized several groups as most at risk. Survey results found that those most at risk were the elderly (88.9%), low-income individuals (74.1%), individuals with disabilities (70.4%), rural residents (48.1%), children (25.9%), and non-English speakers or those with limited English proficiency (29.3%). Other vulnerable populations mentioned included specific faith-based communities and individuals with limited access to transportation. Understanding who is most at risk allows planners to tailor resources, services, and strategies to meet their needs, ensuring timely and effective care.

Of the survey participants, 10 (37%) had prior experience establishing alternate care sites in their community. Seven of these participants specified that these sites were implemented in response to natural disasters, such as tornadoes, high winds, and floods, as well as public health emergencies like the COVID-19 pandemic. The remaining three participants mentioned involvement in an alternate care site setup but did not indicate contexts.

To further understand alternate care site planning in rural communities, interviews were conducted with four hospital emergency managers who had experience establishing such sites during disasters, including tornadoes that caused extensive damage to hospitals, countywide floods, and the COVID-19 pandemic. One major theme from the interviews was the need for adaptability in planning for alternate care sites. The hospital's emergency managers noted that disasters, such as tornadoes, floods, or the COVID-19 pandemic, require different approaches.

Nick Heintz, Regional Director of Safety, Security, and EMS for UnityPoint Health Waterloo/Marshalltown, highlighted the challenge of setting up an alternate care site immediately following a tornado that struck a hospital, where limited infrastructure necessitated rapid mobilization of both resources and personnel. In contrast, a second interviewee, Adam Hadden, Director of Public Health at an Iowa Critical Access Hospital, mentioned that during the COVID-19 pandemic, they were able to "receive the keys to their facility days in advance and set up the appropriate resources." A third interviewee, Stephanie Claussen, Director of Public Health at Adair County Health System, stated that following the evacuation of their hospital after a tornado, it took "a couple of days" for their alternate care site to become fully operational due to a lack of supplies. Because of this, they had to team up with their larger regional healthcare system, vendors, and emergency management to ensure a rapid supply of needed resources, including supplies for mobile radiology, laboratories, primary care clinics, and emergency medical services.

All participants emphasized the role of collaboration among hospitals, public health agencies, emergency management, and community organizations in enhancing alternate care site strategies for disaster preparedness. Claussen shared how a tornado that damaged their facility highlighted the critical role of their regional healthcare system. She described how their healthcare system mobilized executives to assume incident command roles and sent clinical staff to provide care, making sure that their own team members, who were impacted by the disaster, received the support they needed. Similarly, Heintz highlighted that leveraging his regional healthcare system enabled the evacuation of inpatients within an hour of the tornado impacting the hospital. Heintz stated, "Collaboration with UnityPoint Health Waterloo [Regional Health System] was crucial in overcoming the infrastructure and staffing challenges posed by the tornado impact to the Marshalltown Hospital." This networked approach ensured continuity of care for the rural and vulnerable community served.

Heintz also mentioned the value of cross-agency collaboration in disaster preparedness. Heintz noted that the alternate care site was located across town, not on a bus route, and that the community has a significant population of non-English speakers and individuals lacking transportation. By collaborating with local public health, emergency medical services, the Iowa Department of Transportation, and the bus system, they effectively addressed transportation barriers. They developed a multilingual messaging plan to ensure equitable access to care. As Claussen stated, "The success of our alternate care site during the countywide tornado relied heavily on pre-established partnerships with our emergency manager, local agencies, and the

regional healthcare system." This theme was echoed across all interviews, emphasizing how collaboration with key partners such as healthcare systems, emergency management agencies, public health departments, transportation services, local government, and community organizations can lead to the generation of innovative and effective solutions.

When asked about challenges they faced, interviewees shared several common themes, including staffing shortages, logistical coordination, and securing adequate resources. For example, Wendy Hopkins, the Nurse Team Lead for the Disaster Medical Assistance Team (DMAT), the hospital emergency manager involved in flood response, noted that transportation delays due to infrastructure damage limited the availability of medical supplies. She also pointed out that due to the limited availability of buildings within the area, multiple disaster response efforts were often conducted at the same location. This required careful coordination of space, resources, and personnel to ensure that each function—whether medical care, food and water distribution, or sheltering —could operate effectively without disruption. This challenge was also noted by Claussen, who indicated that the Federal Emergency Management Agency (FEMA) Disaster Recovery Center, the Multiagency Resource Center, shelter, and alternate care site were co-located due to a limited number of facilities in the rural town. Despite prior experience emphasizing the importance of resource availability, rural Iowa faces ongoing challenges in securing enough local resources. This is due in part to geographical isolation, limited healthcare infrastructure, and a lack of centralized coordination in Iowa. The interviews reinforced key points from the literature review, particularly the importance of preplanning, collaboration with partners, and innovation to establish an alternate care site regardless of the disaster. The perspectives shared by the interviewees provided valuable insights, highlighting the importance of collaboration with non-traditional healthcare partners to fill care gaps and better serve their communities.

The literature review, survey, and interview reinforced the critical role of alternate care sites in disaster response. The findings point to the need for flexible planning, strong collaboration, and effective resource mobilization. While the COVID-19 pandemic allowed for advanced planning and setup, other events, such as tornadoes, required an immediate response. Across all the disasters, common barriers like resource limitations, especially staffing shortages and logistical challenges stood out. The need to prioritize the care of vulnerable populations was a consistent theme emphasized throughout the literature review, surveys, and interviews. Additionally, the unique challenges faced by rural communities emphasize the importance of conducting research tailored to these specific contexts.

Lessons Learned

The purpose of this paper is to propose alternate care site strategies that enhance preparedness and response efforts to ensure equitable access to care in rural Iowa communities during a disaster. It was achieved through a combination of literature review, surveys, and interviews. The study highlighted the importance of innovation, flexibility, and cross-sector collaboration in

disaster response, addressing the challenges faced by rural communities. Despite awareness of resource limitations, rural Iowa continues to face significant challenges in securing adequate resources. This ongoing struggle highlights the need for creative strategies. Hospital emergency managers expressed interest in regional resource pools, mutual aid agreements, telemedicine, and countywide healthcare coalitions to address these resource limitations. These approaches are insightful and warrant further exploration for their feasibility and practical application in rural disaster response.

Regional collaboration emerged as a critical component of disaster response, extending beyond sharing healthcare resources to building a safety net that leverages regional support while maintaining local health system independence. The interviews with hospital emergency managers from the Marshalltown and Greenfield tornadoes underscored the importance of this balance, ensuring our rural health systems can respond to any disaster without compromising their autonomy.

As a county emergency manager who has witnessed firsthand the strain on rural communities impacted by a tornado, it is clear that collaboration is key to effective disaster response. The final consideration involves evaluating and building on existing partnerships between the emergency management agency, the county's hospitals, the regional health systems, public health departments, long-term care facilities, and community organizations. This will help build a foundation of trust and a strong network to manage our limited resources efficiently.

For future work, several additional areas would benefit from further exploration. First, further research on the regulatory and reimbursement frameworks for rural areas could inform policies to improve the financial and logistical feasibility of establishing alternate care sites in resource-limited settings. Understanding the regulatory and financial aspects will enhance the overall preparedness of rural healthcare systems and contribute to more effective disaster response strategies. Future research should also explore the role of technology, such as telemedicine, in supporting care delivery in rural settings during crises. Telemedicine has the potential to bridge gaps in access, allowing healthcare providers to reach remote populations more efficiently. By examining how telemedicine can be integrated into disaster response plans, communities can develop innovative ways to deliver care, especially when in-person visits are not possible.

Summary

The impact of recent disasters on rural Iowa served as a primary motivator for this paper. Through a multi-faceted approach, including literature review, surveys, and interviews with healthcare and county emergency management professionals, this paper identifies key challenges such as resource limitations, logistical coordination, and staffing shortages while highlighting the necessity of cross-sector collaboration and adaptable planning.

To translate these findings into practice, three priority recommendations are proposed. First, regional collaboration should be established and strengthened by formalizing agreements

between healthcare systems, county emergency management, and local agencies to ensure staffing, logistics, and resource support during disasters. Second, rural communities should develop and maintain alternate care site plans by identifying and pre-designating sites and proactively addressing staffing and resource constraints to meet the community's needs. Third, cross-sector partnerships must be invested in before disasters occur through regular joint planning, training, and exercises that build trust and operational familiarity across partners.

By embracing innovative approaches and collaboration, the healthcare system can become more resilient, providing support to all members of rural communities when disaster strikes. Implementing these strategies will improve healthcare access, protect vulnerable populations, and strengthen disaster response efforts, ensuring that the needs of rural Iowa are met during times of disaster.

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Appendix A

To gather information on current capabilities and perspectives on overall readiness for establishing an alternate care site, a survey of hospital and county emergency managers in rural Iowa was conducted. The survey gathered quantitative data on existing collaboration, perceived gaps in disaster response, and local preferences for care delivery models. The survey was sent in October 2024 and closed in January 2025.

Table A1: Survey question: What type of organization do you represent? 18 Hospital Emergency Managers, 9 County Emergency Managers, zero Other.

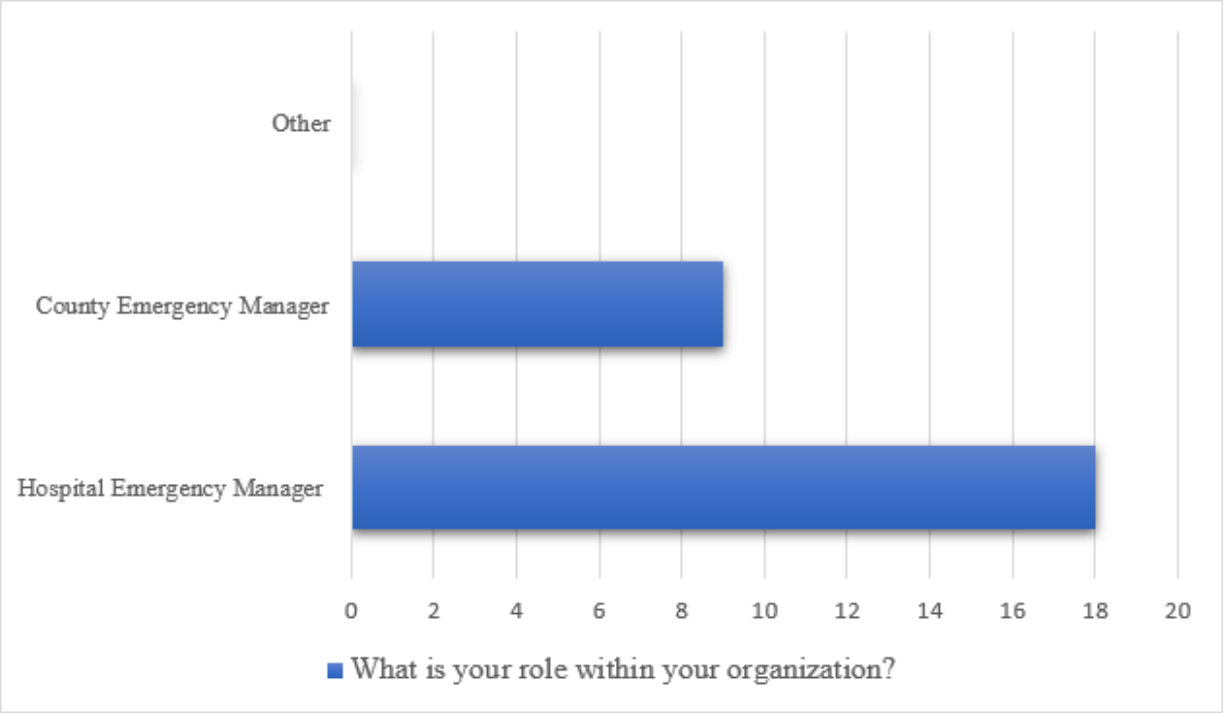


Table A2 Survey Question: How Prepared Do You Feel Your Organization Is to Establish an Alternate Care Site During a Disaster? 0% Very Prepared, 37% Prepared, 33% Neutral, 26% Less than Prepared, and 4% Not Prepared.

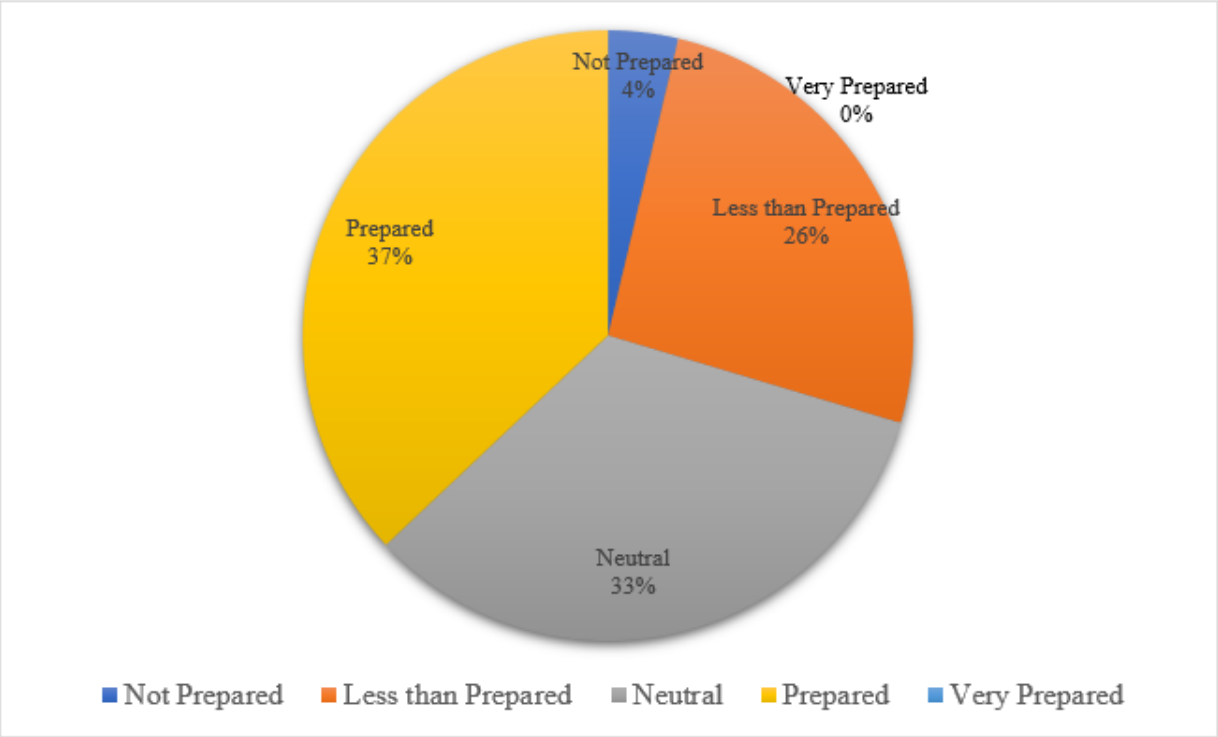


Table A3 Survey Question: Which specific populations in your community do you think are most at risk of facing barriers to access during a disaster? 24 Elderly, 20 Low-Income Individuals, 19 Individuals with Disabilities, 16 Non-English Speaking Individuals, 14 Rural Residents, 7 Children, 1 Amish, 1 No Transportation.

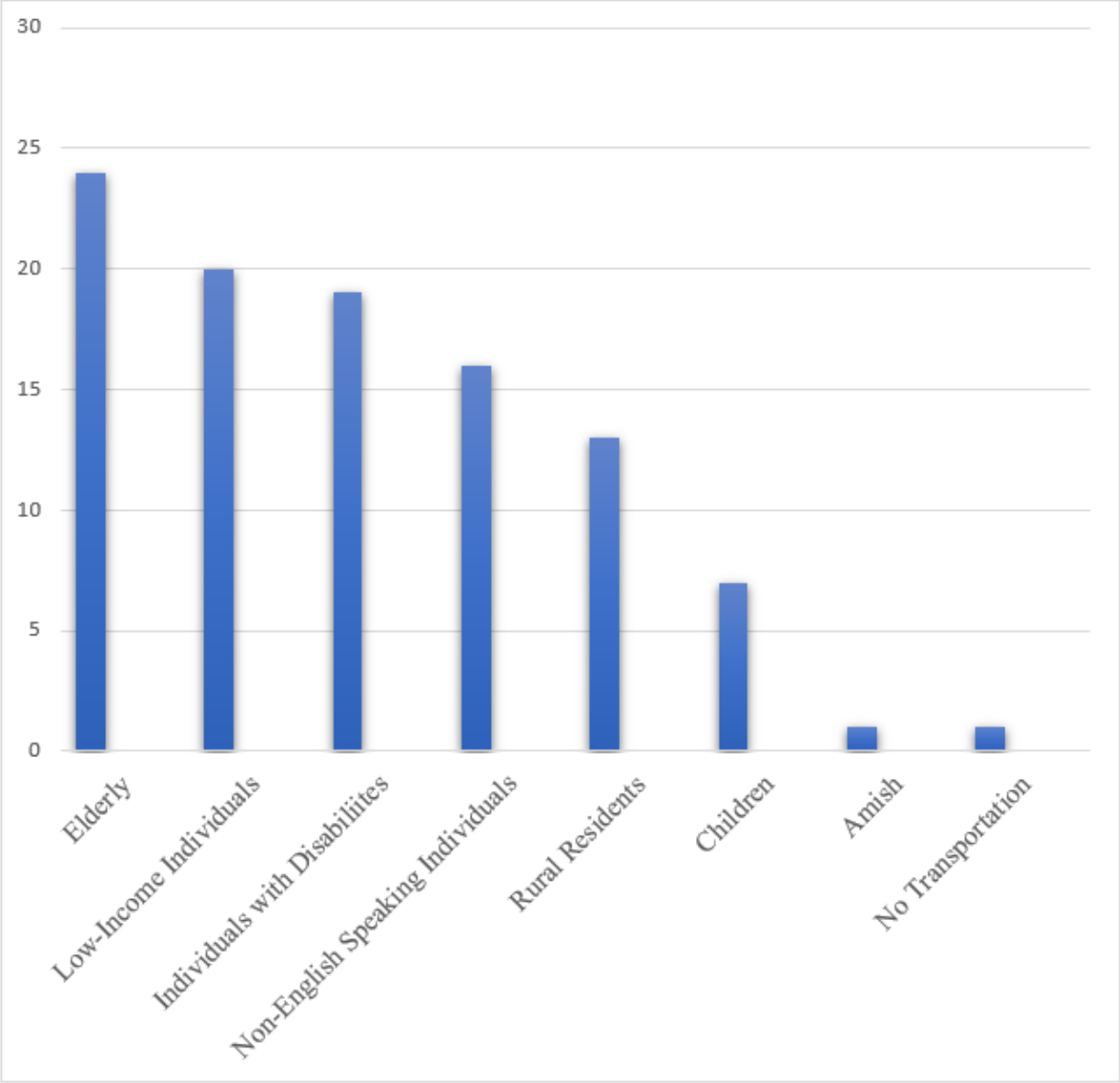


Table A4 Survey Question: What strategies do you believe are necessary to improve disaster preparedness in your community?

Personally identifiable information was removed from the responses to maintain anonymity while preserving the context. Responses were then categorized into four themes – Stakeholder Engagement, Resource Challenges, Training and Exercise, and Vulnerable Populations.

Participant Number	Response Summary	Theme
1	Regular meetings with public officials	Stakeholder Engagement
2	Additional staffing all across the board, employees are stretched thin	Resource Challenges
3	Enhance our public/private partnerships with our NGOs	Stakeholder Engagement
4	Bringing more organizations such as schools and care facilities to the table	Stakeholder Engagement
5	Overall, I feel our relationship w/ all of our stakeholders are very good.	Stakeholder Engagement
6	More meetings on a local level	Stakeholder Engagement
7	Need to get the county healthcare coalition back and running, but get push back from local EMA	Stakeholder Engagement
8	Funding, stakeholder engagement	Stakeholder Engagement Resource Challenges
9	A Community Emergency Management Council comprised of local partners	Stakeholder Engagement
10	Frequent connections between stakeholders and alternate care site administrators would keep the need at the forefront of most minds.	Stakeholder Engagement
11	Build on relationships, very strained before and more so now; lack of EM and dispatch/sheriff support and lack of support in areas they are needed and said they would support	Stakeholder Engagement
12	Additional training together	Training and Exercise
13	Stakeholder participation in meetings. We have many meetings but attendance is low.	Stakeholder Engagement
14	Finalizing initiatives and building other action plans to provide education after preparedness and testing of plan is complete	Training and Exercise

15	We currently do not have a local coalition. We need to restart this group to open communication and plan for disasters.	Stakeholder Engagement
16	I think, for the most part, we communicate well. With that said, there seems, at times, to be some confusion of what my role is within their structure.	Stakeholder Engagement
17	Transportation options	Resource Challenges
18	Bilingual support and low-income resources	Resource Challenges
19	Funding and buy in from administrator and government officials.	Stakeholder Engagement Resource Challenges
20	More public health involvement	Resource Challenges
21	A statewide access and functional needs planner/advisor	Resource Challenges
22	Pockets of people who are not as informed and prepared as we would like them to be	Vulnerable Populations
23	Knowing where those with special needs are located exactly for timely response.	Vulnerable Populations
24	Designated site for alternate care sites that within the city if something happens this site is activated it should not just each facility figuring it out it should be mandated by the resources and officials within that community	Resource Challenges
25	Public Service Announcements that are shared by all.	Vulnerable Populations
26	Every MOU or alternative site is set up for a 1 - 2-day event. Most needs are long term events (flooding)	Resource Challenges
27	Being a small rural county, we are limited in sites.	Resource Challenges

Table A5 Survey Question Have You Been Involved In The Establishment Of Any Type Of Alternate Care Site? 63% No, 37% Yes

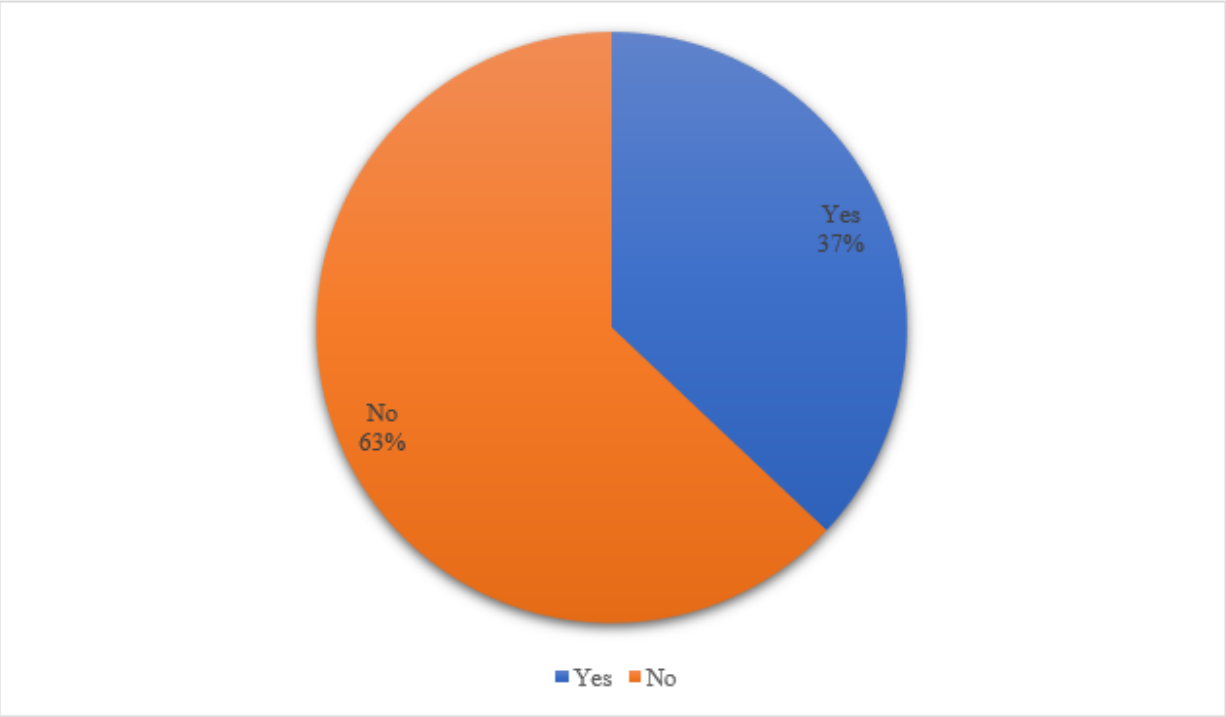
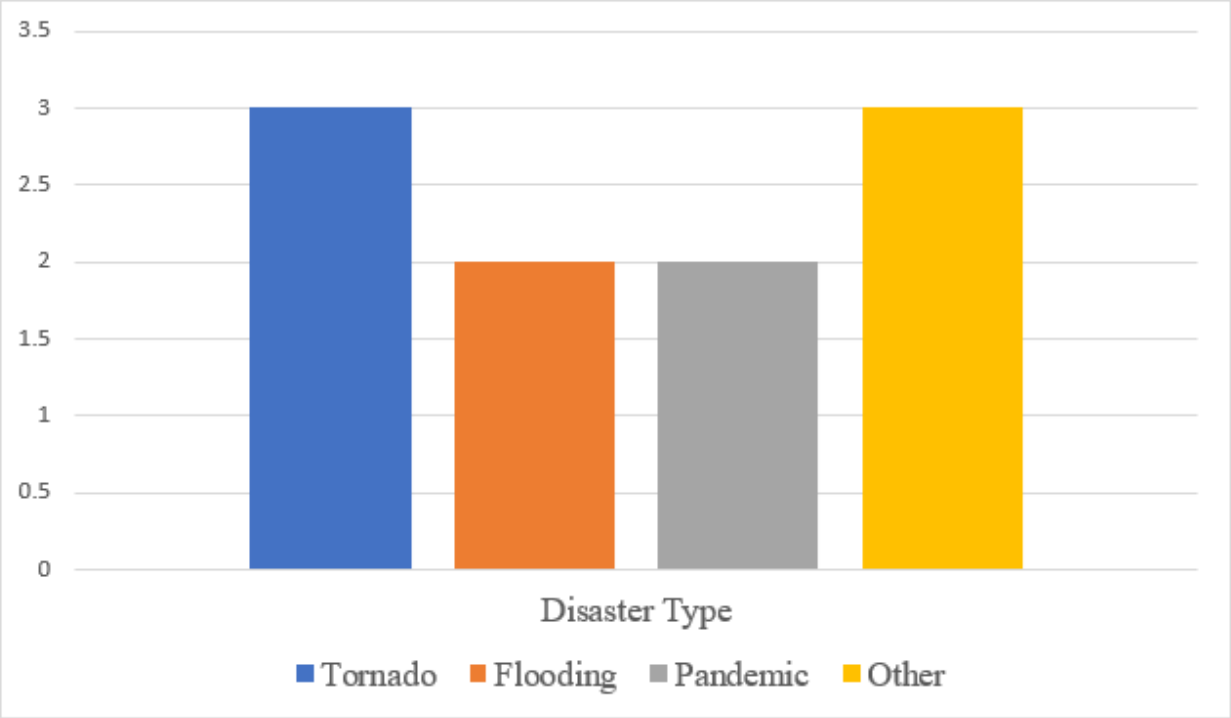


Table A6 Survey Question What type of disaster prompted the need for setting up the alternate care site? 3 Tornado, 2 Flooding, 2 Pandemic, 3 Other



About the Author

Lynn Royer joined the Dallas County Emergency Management Team in July 2023. A long-time Dallas County, Iowa, resident, she brings an extensive background in healthcare and emergency preparedness to her role.Lynn served over 20 years in the United States Air Force and Iowa Air National Guard as a Flight and Operational Medic, retiring in 2017. She earned her NREMT certification in 1997 and became a Registered Nurse in 2000. For 17 years, Lynn worked as a Public Health Nurse with the Dallas County Health Department, where she managed the Immunization Program and the Public Health Emergency Preparedness Program.

In 2017, she became the Public Health and EMS Coordinator for the Central Iowa Healthcare Coalition, overseeing planning, coordination, implementation, and evaluation of public health preparedness programs and EMS system development across a 14-county region.

Lynn has responded to multiple large-scale incidents, including the 2008 Iowa floods, 2009 H1N1 pandemic, 2018 Southwest Iowa water outage, 2018 Midwest tornado outbreak, 2019 COVID-19 pandemic, 2020 Corn Belt derecho, 2024 Perry School shooting, and the 2024 Greenfield tornado. Outside of work, Lynn is a proud mom of three energetic, sports-loving boys, where she continues to hone her skills in coordination, planning, and adaptability.

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