

# Calm in the Chaos

## Leading through Disaster

Greenfield EF4 Tornado| ACHS Response,  
Recovery and Lessons Learned

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# Session Objectives

## Operational, regulatory, and infrastructure impact

Examine what a tornado meant for a critical access hospital.

## Emergency activation and HICS implementation

Evaluate leadership roles, command structure, and decision-making.

## Continuity of operations strategies

Identify alternate care sites, regional partnerships, and regulatory coordination.

## Insurance and financial recovery

Recognize why comprehensive coverage and documentation matter.

## Employee support and psychological safety

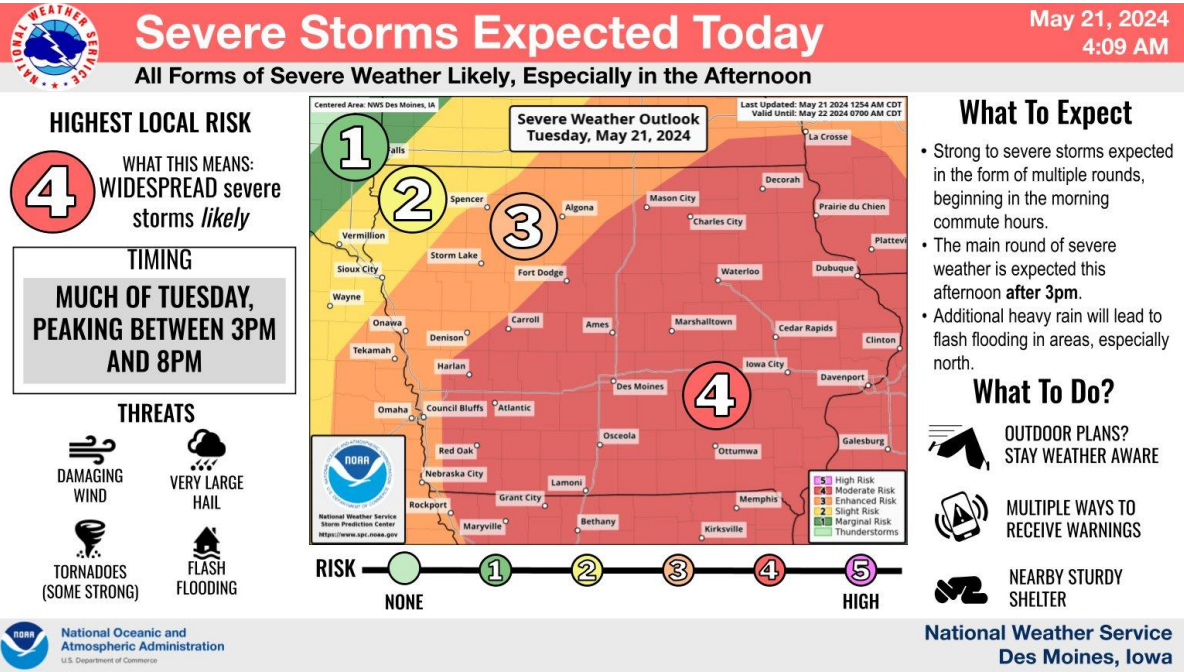
Understand staff support during prolonged disruption.

## Preparedness and risk mitigation

Apply practical strategies before the next disaster.

# Incident Overview

Greenfield, Iowa | May 21, 2024



## Why the Setting Matterred

### Critical Access Hospital

Serving Adair County and surrounding rural communities

### County EMS

Ambulance service operated through ACHS

### Impact Zone

Hospital and EMS station were in the damaged area

### No Inpatients

Zero inpatients at the time of impact

### During the response, ACHS simultaneously became:

- A damaged healthcare facility
- A responding EMS agency
- A triage and transport partner
- A continuity-of-operations organization

## Pre-Event Preparedness That Mattered

### Training Foundation

NIMS/HICS training, exercises, and emergency preparedness work created a starting structure.

### Local Coordination

EMA, Public Health, LEPC, law enforcement, fire, EMS, and community partners were already connected.

### Regional Coalition

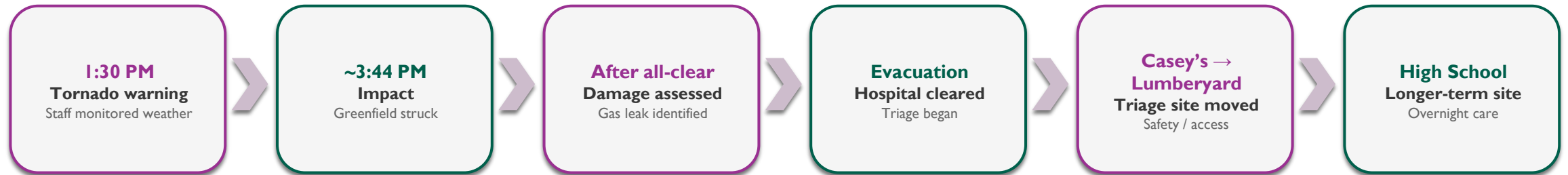
Central Iowa Healthcare Coalition and MercyOne affiliates were part of the support network.

**Preparedness did not make the event easy. It gave the team a framework to adapt from.**

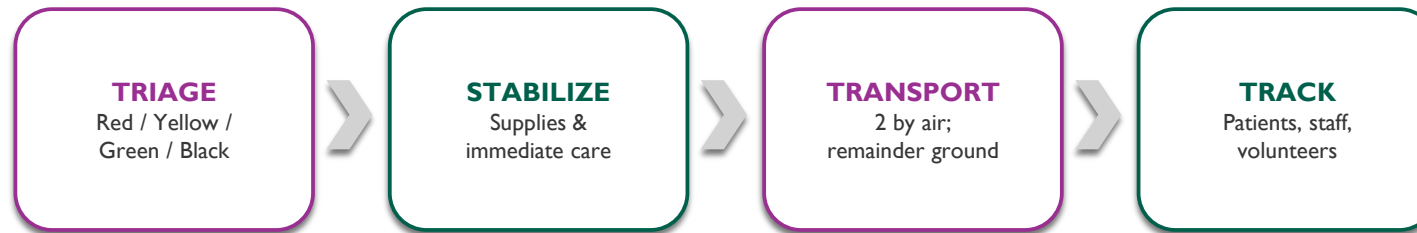
# INITIAL RESPONSE & PATIENT MOVEMENT

The team moved from sheltering to evacuation, triage, transport, and off-site continuity.

## FIRST HOURS



## PATIENT MOVEMENT & THROUGHPUT



### AT IMPACT

- 0 inpatients
- Surgery completed for the day
- 3 ED patients discharged after evacuation
- Clinic/outpatients sheltered; no injuries
- Patients transferred throughout the region and to Des Moines

Deviation from plan: ACHS could not serve as the receiving hospital — the response shifted to triage, transport, and continuity operations.

# INFRASTRUCTURE IMPACT

Damage was not isolated to one area — it changed how, where, and when care could safely resume.



Hospital exterior



Med-Surg



Emergency Department



Surgery



Lab



Roof / building envelope

The infrastructure damage changed the response model: **ACHS** could not simply reopen one department — supporting systems, safety, construction, staffing, and regulatory readiness all had to align.

# Command, Leadership, and Role Clarity

Incident command helped organize chaos, but role clarity became a lesson

## HICS Activated

Hospital Incident Command supported hospital operations and continuity.

## EOC Coordination

Hospital/EMS command coordinated with community EOC and responders.

## External Support

MercyOne affiliate leaders helped fill leadership and administrative roles.

## Lesson Learned

Clarify ICS roles and pre-hospital scene expectations before the incident.

**Leadership does not mean that one person has all the answers. It means creating enough structure for people to make the next safe decision.**



# Regulatory Coordination

From survey mindset to recovery partnership

## Regulatory partners helped ACHS safely restore services while meeting requirements.

### CLIA

Approval to provide lab services at the elementary school

### DIAL

Plans submitted for outpatient operations and emergency preparedness

### Life Safety / Fire Marshal

Walk-throughs and approvals for school, fitness center, and hospital spaces

### Building Code / Construction

Ongoing coordination as areas were repaired and reopened

**A practical lesson: continuity is not just finding a room. It is safety, equipment, staffing, policies, inspections, and patient communication.**

# Operational Continuity

Temporary operations had to be built, staffed, supplied, and communicated

## Alternate sites are not real until the details are real.

- Temporary walk-in/clinic care established in community locations
- Nodaway Valley became a “home away from home” for operations
- FEMA, Red Cross, and Heart of Iowa co-located at the school
- Services expanded only as safety, staffing, equipment, and approvals allowed



# Communication and Information Management

Redundancy became the real lesson

## Staff notification

Employee cell phone list, Text-Em-All, I Am Responding,

## Radios

700 MHz/pre-programmed channels were a strength; capacity review led to additional needs

## Public messaging

Hospital status, closed signage, relocation, and available services had to be communicated quickly

## Backup access

PIO processes, backup platform admins, and remote/online access matter

**Do not rely on one channel when the building, phones, people, and community infrastructure are all affected.**



# Employee Support and Psychological Safety

Staff were responders and disaster victims

## No staff injuries

No employees were injured at work or home.

## 19 employees impacted

Major home damage or loss affected staff personally.

## Paid employees

Employees were paid working or not working; no PTO required.

## Mental health support

Debriefings, counselors, churches, pantries, and support applications.



**Planning for staff as disaster victims is operational planning.**

# The 24/7 Care Lesson

Too much too soon is a real risk

**A rapid 24/7 service model helped meet community need — but staff stress and fatigue became visible quickly.**

## What happened

Temporary care began around the clock, then severe storms returned and staff stress escalated.

## What changed

Operations were reduced to a more sustainable schedule and outside/travel staff were used for relief.

## The lesson

A continuity plan must include staffing endurance, not only staffing coverage.

**Burnout planning belongs in the emergency plan, not just the recovery conversation.**

# Financial Recovery and Insurance

Coverage and documentation shaped the ability to recover

## Estimated Cost Summary

Hospital repair, contents, extra expense, EMS rebuild, and business loss.

## Comprehensive Coverage

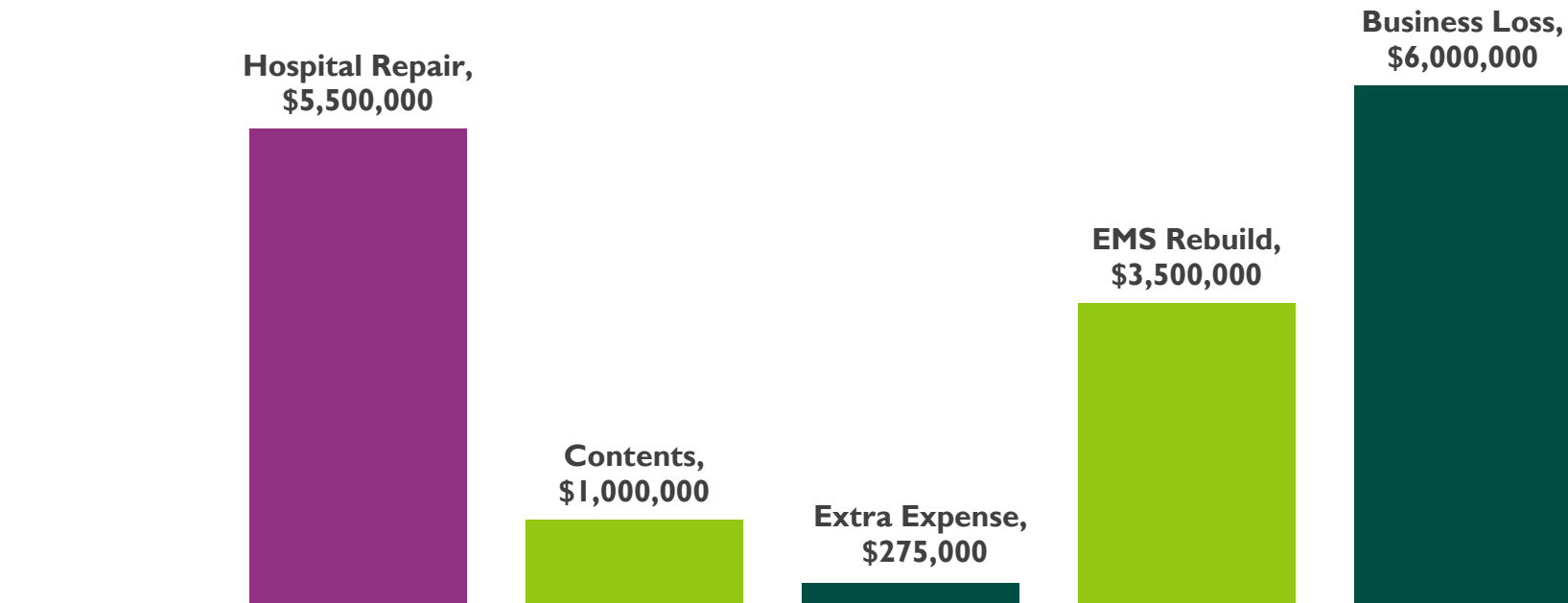
Business income loss coverage helped pay employees while operations were shut down.

## FEMA Role

Reimbursement focused on the deductible and items not covered by insurance.

## Cash Flow

Early insurance payment helped support immediate recovery needs.



# Department-Specific Continuity Needs

Every department had a different “must-have” list

## Surgery

Sterile supply temperature ranges, vendor contacts, off-site sterilization options

## Lab

Analyzer replacement, mobile chemistry, supplies, downtime forms, storage tracking

## ED

Safe reopening depended on lab, CT, EMTALA/waiver considerations, and construction

## Radiology

Patient rescheduling, orders/PAs to other facilities, vendor detail tracking

## Pharmacy

Board/DEA coordination and medication delivery constraints

## Payroll/HR

Pay practices, staff contact, PTO, incentives, and support

**Improvement: department-specific emergency guides, supply lists, vendor contacts, and continuity actions.**

# Regional and Community Partnerships

Relationships were infrastructure

- MercyOne affiliate leaders supported HICS and operational planning
- Madison County and other regional hospitals helped with patient care continuity
- Local schools, churches, businesses, and volunteers provided space and support
- EMA, EOC, public health, EMS, fire, law enforcement, and state partners coordinated response
- Relationships built before the disaster made the response faster



# Recovery Was a Phased Process

Recovery was not one reopening date — it was a phased process of restoring safe care, rebuilding infrastructure, and supporting staff and the community.

- May 21** Hospital closed; EMS remained operational
- May 22** Temporary care established at church and school
- June–July** Regulatory approvals expanded lab, x-ray, and therapy services
- August** Partial return to ACHS; EMS and therapy used temporary locations
- November 11** All hospital services officially reopened
- Today** New EMS station and ongoing preparedness improvements



Temporary operations at Nodaway Valley



Temporary clinic space



Phased return to ACHS services

# Strengths Identified in the AAR

What worked and should be maintained

## Incident Management

Strong leadership, beneficial meetings, calm under pressure

## Information Management

Staff lists, Text-Em-All, I Am Responding, PIO coordination

## Patient Movement

Transported patients in a timely manner; mutual aid response

## Operational Continuity

Rapid clinic setup, flexible staff, community support

## Employee Support

Mental health, debriefings, staff resources, payroll support

## Insurance

Business loss and property/contents coverage supported recovery

## Areas for Improvement

### Clarify command roles

NIMS/HICS roles, leadership structure, and pre-hospital expectations

### Define triage/alternate sites

Predetermined triage and ambulance staging locations  
MOUs, Wi-Fi, phones, supplies, accessibility, and usable spaces must be known.

### Backup communication

Radios, PA systems, mass notification, backup admins

### Mobile supply kits

Triage, transport, forms, patient tracking

### Tracking systems

Supplies, equipment, patient movement, staff time, volunteers

### Training and drills

Evacuation, MCI, off-site ICS, and continuity operations

**The core challenge: operating as a responder while also losing normal hospital and EMS infrastructure.**

# LEARNING TRANSLATED INTO IMPROVEMENTS

## Before

EMS station vulnerable to the same incident

Alternate sites identified, but operational detail varied

Response exercises emphasized initial incident

Department plans uneven across services

Weather notices and communication tools less integrated

## Now

New EMS station / revised continuity planning

Expanded planning for school/community sites

Drills expanded to evacuation, off-site ICS, and continuity

Department-specific emergency guides and supply lists

WENS implemented; separate Teams and phone-system weather alerts added



New EMS station

# RECOMMENDATIONS

1

## **Exercise the loss of your own facility**

Do not only drill patient surge. Drill evacuation, off-site ICS, and continuity.

2

## **Build communication redundancy**

Test radios, staff notification, PIO processes, and backup platform access.

3

## **Make alternate sites real**

Confirm MOUs, Wi-Fi, phones, space, supplies, accessibility, and setup needs.

4

## **Track everything from the start**

Patients, staff, volunteers, equipment, donations, expenses, and time all matter.

5

## **Plan for staff as disaster victims**

Family needs, mental health support, payroll, and burnout are operational issues.



# KEY TAKEAWAYS

## **Preparedness gives structure.**

Adaptability drives the response.

## **Relationships are infrastructure.**

Build them before the disaster.

## **Recovery starts during response.**

Continuity is not a separate chapter.

### **One must-do action**

**Exercise what happens when your facility cannot function as intended.**

*“Preparedness is not only surviving the disaster. It is sustaining care, adapting quickly, and being better prepared for the next one.”*

## Photo and Source References

- National Weather Service / NOAA damage survey and severe weather outlook graphics
- ACHS and prior executive tornado presentations
- Greenfield EF4 Tornado ACHS After-Action Report / Improvement Plan
- Photo sources: Eric Hanson KCCI/Facebook, Des Moines Register, Adair County Iowa Historical Society, Dan Dickinson, Congressman Zach Nunn, and ACHS internal photos