PRACTICAL ICS FOR HOSPITALS

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The Incident Command System (ICS) is a standardized approach to the command, control, and coordination of emergency incident management in the United States. ICS is an operational system that enables staff – including those from multiple agencies or organizations – to set priorities, manage resources, share information, and coordinate together effectively during response. ICS is used during emergency responses, but it can also be applied to other projects or situations that are not easily managed with day-to-day structures. The Emergency Management Basics and the Emergency Management Cycle chapter of this Guidebook provides information about the broader scope of emergency management. Additionally, the Mass Casualty Incident Planning and Surge Concepts chapters offer insights into key operational roles of ICS. This chapter focuses on how the ICS structure can be effectively applied to the hospital environment. It should not be used as a tutorial or introduction to ICS.

Origins of ICS

ICS was developed by southern California fire services in the 1970s to improve coordination among multiple agencies during wildfire response.[1] Prior to that, the involvement of numerous agencies and resources—combined with inconsistent organizational structures, communication frameworks, and terminology—often created confusion, delays in response, and significant life safety risks. Since then, ICS has been widely adopted as the standard organizational structure among public safety agencies, especially fire departments, which apply it consistently on every response.

To meet the need for a hospital-specific ICS framework, the California Emergency Medical Services (EMS) Authority developed the Hospital Emergency Incident Command System (HEICS). Originally used informally in

Related Resources
Additional materials are available in ASPR TRACIE's Incident Management Topic Collection.

[1] https://firescope.caloes.ca.gov/SiteCollectionDocuments/ICS%20History%20and%20Progression.pdf

California during the 1980s, HEICS was formalized in 1991 by the Orange County EMS Authority and quickly became a national resource. The framework was renamed the Hospital Incident Command System (HICS) during a 2006 revision.[2] HICS provides an incident response organizational structure tailored to health care operations, along with job action sheets for each position. Another revision in 2014 updated these job action sheets and included Incident Planning Guides (IPG) and Incident Response Guides (IRG) for various emergency scenarios and a new guidebook. Today, HICS is the primary ICS model used by hospitals. Note that HICS is an incident management *organizing framework* that includes a generic set of positions and functions designed for any incident for execution of the hospital's Emergency Operations Plan**;** it is not a response plan.

In 2004, the U.S. government adopted the National Incident Management System (NIMS) as the nation's comprehensive approach to incident management. It defines operational systems (including ICS) that enable personnel from various agencies and organizations to work together during any type or size incident by ensuring consistent approaches to command and coordination, resource management, and communications/information management. Public agencies and entities receiving federal preparedness and response funds are required to use a NIMS-compatible ICS structure, such as HICS.

This chapter uses "ICS" generally rather than "HICS" or other terms for a hospital's incident response organizational structure. The Other Hospital Adaptations section of this chapter highlights how some hospitals or their parent health systems have modified these structures to better align with their day-to-day operations. Regardless of their approach to incident management, every hospital should have a defined response organizational structure and pre-identified and pre-trained staff for each of the ICS roles expected to be needed.

ICS Structure

ICS shares a common top-level structure composed of the Command and General Staff, as illustrated in Figure 1. Many hospitals follow the HICS modification, including Medical/Technical Specialists in their Command Staff. Beneath this top-level, a hierarchy of supervisors, unit leaders, and other positions are activated as needed to meet the specific demands of the incident.[3] The full ICS structure can seem complex, but it effectively outlines all the functional areas that may need activation. The ICS structure is rarely fully activated. If a position is not activated, responsibility defaults to the next active position above it in the organizational structure. Individuals assigned to an ICS role should have sufficient expertise to allow them to

[2] California Hospital Association. (n.d.). Hospital Incident Command System (HICS). (Accessed 9/10/2026.)
[3] HICS provides an expanded version of Figure 1 including Medical/Technical Specialists as part of the Command Staff and showing the Branch Director and Unit Leader roles below the General Staff. Hospital emergency managers can customize this structure using HICS Form 207, available at https://calhospital.org/wp-content/uploads/2024/10/hics_207-hospital_incident_managment_team_himt_chart.pdf.

operate but, by necessity, individuals may be assigned supervisory roles they do not hold in the day-to-day organizational hierarchy.

Figure 1. ICS Command and General Staff[4]

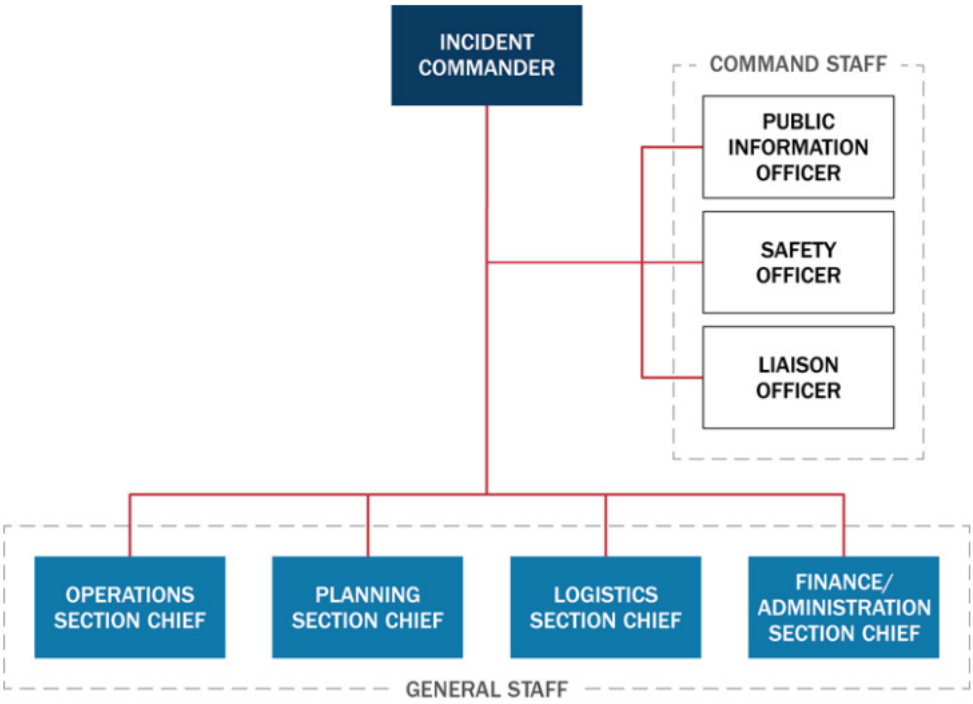


Table 1 includes a brief description of the Incident Commander role and each Command and General Staff position.

Table 1. Brief Descriptions of Top-Level ICS Positions.

ICS Position	Description of Role
Hospital Incident Commander	Has delegated authority from hospital leadership and oversees management of the incident, making key decisions, setting priorities, and providing direction to the hospital's response team.
Public Information Officer (PIO)	Coordinates external communications (and usually internal as well), ensuring that staff, patients, families, and the media receive clear and accurate information about the incident. The PIO also monitors media for issues that may affect the response or need to be addressed/corrected.
Safety Officer	Responsible for maintaining a safe environment for all staff, patients, and responders, the Safety Officer monitors for hazards, oversees facility protection measures, mitigates identified safety issues, and enforces safety practices during the response.

[4] Federal Emergency Management Agency. (2017). National Incident Management System: Third Edition. U.S. Department of Homeland Security.

ICS Position	Description of Role
Liaison Officer	Serves as the main contact between the hospital's ICS team and outside agencies or partners (including the Emergency Operations Center [EOC] if activated in the community), updating partners on hospital status and coordinating with local emergency operations.
Medical/Technical Specialists	Though infrequently used in fire response (and not shown in Figure 1), these positions are often crucial to making health care operational decisions, particularly under crisis conditions or when infrastructure is compromised. Examples include the use of critical care physicians to inform surge strategies for the intensive care unit (ICU), infection preventionists to define personal protective equipment (PPE) policies, or toxicologists to inform chemical incident response.
Operations Section Chief	Leads the section that implements response tactics, deploys resources, manages patient care operations, and ensures that strategies identified by the Incident Commander are carried out.
Planning Section Chief	Oversees the collection, evaluation, and dissemination of incident data. Tracks resources, anticipates needs, prepares situation reports, develops plans for demobilization, and drafts the Incident Action Plan.
Logistics Section Chief	Ensures the hospital has what it needs to operate during the incident, including food, water, equipment, medical supplies, communications, and facilities support. Responsible for acquiring and allocating all support resources.
Finance/Administration Section Chief	Monitors and documents expenses, manages contracts and claims, tracks personnel time, conducts cost analysis, and assists in the recovery of expenditures/losses related to the incident. Also addresses regulatory and legal issues generated by the response.

Whenever possible, Command and General Staff titles should remain consistent to support integration and communication with external agencies and other hospitals. Below these top-level positions, hospitals often tailor role names to align with daily operations (e.g., renaming "Casualty Care Supervisor" to "ED Supervisor"). When selecting staff for identified ICS roles, the hospital emergency manager should consider both those in day-to-day leadership roles and individuals whose routine roles are closely aligned with needed ICS positions to enable a more seamless transition to an emergency response role. During day-to-day operations, hospital chain of command typically flows from the unit charge nurse to the nursing supervisor and then to the administrator on call, for example. When assigning positions under ICS, every effort should be made to preserve these familiar roles, contact information, and decision-making pathways to maintain continuity.

The emergency manager ensures the ICS scope and structure fit the hospital (which may include ambulatory, post-acute, and other service lines located outside of the primary hospital building) and that all staff have the training and resources needed for an effective response. During an incident, the emergency manager often provides critical support, particularly within the Planning Section and ensuring response coordination with external partners. Familiarity with key hospital leaders enables emergency managers to anticipate needs and quickly gather information others may not easily access. In the event the emergency manager is unavailable

when an incident occurs, hospitals should provide physical and digital job action sheets, checklists, and other resources for each ICS position. Doing so can support initial required actions, thereby reducing reliance on one individual's knowledge.

Generic ICS job action sheets *must* be customized for the hospital and role (and shortened for clarity as needed). Larger hospitals that have emergency management responsibility for other service lines should designate an ICS position to coordinate support to ambulatory and other sites that are directly involved in the incident and/or response. Smaller hospitals often need to consolidate job action sheets and expectations for the limited ICS positions they can staff.[5] A further challenge for smaller facilities is that those assigned to Command and General Staff roles often cannot be fully relieved from their clinical and administrative duties to focus exclusively on incident command.

Hospital Command Center

The Hospital Command Center functions as the facility's equivalent of an EOC. It serves as the hub for key ICS positions (as described in Table 1) and provides a space for decisionmakers to convene, share information, and coordinate support for the incident. Staff in designated ICS positions typically operate from the Hospital Command Center when the incident is significant enough to warrant activation.

The location of the Hospital Command Center—and its backup site—should be known to all hospital leaders. It is often a centrally located conference room, classroom, or other designated space. Key attributes include the following:

- Relatively central but secure location, often without external windows or doors.
- Large enough for the number of expected Command, General, and ICS support staff.
- Multiple white or "smart" boards available.
- Central table with multiple phones and electrical jacks.
- Multimodal telephone/teleconference capabilities, including landlines, as Voice Over Internet Protocol phones may be affected by the loss of internet connectivity.
- Multiple desktop or laptop computers with high-speed wireless network and access to all clinical and administrative networks.
- Connectivity to external television (and, optimally, to security camera feeds).
- Adjacent workrooms for meetings and other needs.
- Full electrical and heating, ventilation, and air conditioning (HVAC) backup to generator.
- Access to bathroom(s) and refreshments.

The Hospital Command Center should be equipped with essential resources, including identifying vests for key ICS roles, radios and backup communication devices/systems (e.g., satellite phone, amateur radio), office supplies, printer/copiers, flashlights, and critical forms, policies, and hard and digital copies of reference documents. These should include the

[5] HICS documents modified for small hospitals are available through the Association of Healthcare Emergency Preparedness Professionals.

hospital's Emergency Operations Plan, all annexes, IRGs, job action sheets for each position, and other job aids such as checklists and templates. Printed materials should also be available in other formats such as being posted on a hospital intranet page or stored on a USB drive.

Hospitals are increasingly activating their ICS either fully virtually or as a hybrid model whereby the Hospital Command Center is physically open but also has a virtual option, particularly for smaller-scale incidents. This allows Command and General Staff to join briefings and contribute to decision-making while enroute to the hospital or from another location. For hospitals that are part of a larger health system, this can also allow parent health system leaders to participate or monitor the situation. To ensure success, leaders who may assume ICS roles must know how to activate the virtual Hospital Command Center, and this capability should be regularly tested through exercises.

ICS Features

ICS incorporates the following core features designed to enable a structured and coordinated response:

- **Consistent and scalable organizational response structure**: Provides a standardized framework that can expand or contract to meet the needs of any incident.
- **Standardized terminology**: Ensures uniform naming conventions for key roles and positions.
- **Clear chain of command**: Communication and decision-making follow a defined, sequential pathway. Each decision aligns with the authority and scope of the position, and unresolved issues are escalated to the next level.
- **Delegation of authority**: Provides the Incident Commander with sufficient authority to execute the response.
- **Span of control**: Each supervisor should manage no more than five to seven direct reports to maintain effectiveness and accountability.
- **Comprehensive communication plans**: Ensures clarity, consistency, and reliability in information exchange throughout the response.
- **Resource request and management system**: Establishes a standardized process for requesting, tracking, and allocating resources efficiently.
- **Standardized forms**: Utilized across agencies to capture critical information, including situational updates, operational activities, communication records, and safety plans.
- **Operational periods**: Specific timeframes within which defined objectives and actions are to be accomplished. These operational periods may range from hours to days depending on incident dynamics.
- **Management by objectives and incident action planning**: Establishes clear, measurable objectives and documents strategies and tactics to guide operational activities.

Usually in ICS there is clear authority over the incident (e.g., the hospital Incident Commander is responsible for the hospital). However, that may change depending on the nature of the incident (e.g., the fire department Incident Commander will have overall authority during a fire

at the hospital and the law enforcement Incident Commander will have authority over a hostage situation in the facility).

When more than one facility/agency has a lead role in a response, there are two major constructs that should be familiar to hospital emergency managers. Unified Command occurs when two or more entities have both responsibility and authority over the resources, and they work directly together to manage the incident. A Multiagency Coordination System (MACS) is a structure used when incident coordination is critical, but the involved partners do not have specific authority. An example of a MACS is a health care coalition where EMS, hospitals, public health, and emergency management can all coordinate during a response but do not have specific authorities to direct the involved agencies/facilities.

Health care coalitions, multiagency coordination groups, and other constructs that lack formal command authority commonly refer to "incident *management*" rather than “incident command” when using ICS in structures such as a MACS.

ICS Implementation

Effective use of ICS requires both an understanding of its concepts and practical experience gained through exercises and real-world incidents. Compared to fire services, hospitals often encounter unique challenges when implementing ICS, as outlined in Table 2.

Table 2. Differences in ICS Implementation Between Fire Service and Hospitals

Fire Service	Hospital
Uses ICS as the default organizational structure, with positions and authorities integrated into daily operations—making ICS standard practice and familiar to staff.	Uses ICS only during incidents and exercises, creating an unfamiliar structure in a high-stress environment; positions and duties are not part of daily operations, and expectations often conflict with routine processes.
ICS positions activated are generally consistent.	ICS positions activated can vary significantly based on the incident type.
Chain of command used to identify and address all supply/logistics needs.	Supply and logistics needs are usually met by a variety of daily unit-based actions.
ICS is implemented immediately, with the Incident Commander responsible for directing initial actions.	Activation of Hospital Command Center may be delayed unless the hospital has advance notice of the incident; initial unit-based actions are led by a supervisor who assumes the incident command role until the designated Incident Commander is in place.
ICS is based on a vertical organizational structure with a clear chain of command.	A mix of horizontal and vertical organizational structures makes following hospital chain of command more difficult.
Command and General Staff are the most experienced individuals with leadership positions based on their incident response expertise.	Command and General Staff are often hospital leaders from a variety of disciplines with limited experience with the ICS or incident response.

These differences help explain why hospitals often face challenges in implementing ICS effectively. However, there are strategies and solutions that can align ICS best practices with the realities of hospital response. Adapting ICS for hospitals requires balancing the benefits of its standardized structure with the realities of hospital operations. This adaptation places greater emphasis on unit-level response and problem-solving than is typical in public safety applications.

Unit-Level Preparedness

Although the fire service uses ICS for all responses, certain actions in the first minutes—such as initial engine company duties—are automatic and not directed by the Incident Commander. Hospitals need similar ingrained, role-specific actions for each unit based on incident type (i.e., predefined action steps based on specific triggers). The emergency manager should ensure that units such as the emergency department (ED), surgical services, security, facilities, and support areas like pharmacy, radiology, blood bank, and laboratory have the supplies, concise checklists, and other resources to guide their initial actions. These units also require the training (including practice through drills and exercises) to act immediately. Success in situations like mass casualty incidents (MCIs) often depends less on the Incident Commander directing activities and more on the preparedness of individual units. Notification procedures should trigger the availability of additional resources, assumption of ICS roles, and activation of the Hospital Command Center.

Emergency managers and committees play a critical role in ensuring these frontline responses are effective. Unit-level plans and resources should sustain operations for the first 30–60 minutes, allowing ICS staff in the Hospital Command Center to establish situational awareness and assume broader operational control. Early actions cannot rely on the pre-designated Incident Commander, who may not be positioned to make strategic decisions during this initial reactive incident phase.

Incident Action Planning

Because activation of the Hospital Command Center will likely lag behind initial unit-level actions, it should focus first on gathering information and supporting—not directing—early response.[6] Over time, as priorities shift from reactive measures to proactive planning, the Hospital Command Center's role becomes more important. To establish situational awareness, Hospital Command Center staff should gather information from the most affected areas of the

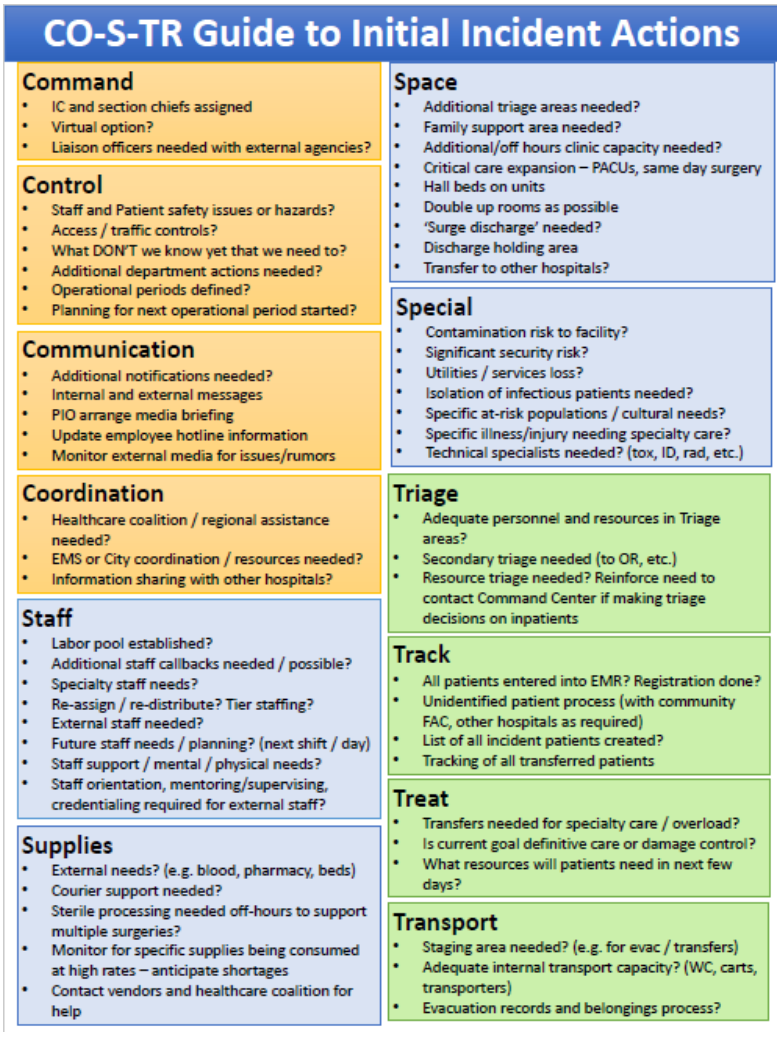
From the Field
At Sunrise Hospital in Las Vegas, the response to the Harvest Festival shooting was described by a leader as "like a jazz band" where everyone knew their instruments and each other well enough that they were able to harmonize and follow each other's lead despite a lot of necessary improvisation.

[6] The Hospital Command Center will be activated quicker during an incident on or very close to the hospital campus (e.g., the Boston Marathon bombing or the Pulse nightclub shooting) or for an incident with advance warning (e.g., an expanding disease outbreak leading to hospital patient surge).

hospital without disrupting their operations. In some cases, a brief report may suffice; in others, someone in a designated ICS position may need to visit key areas (e.g., the ED or pre-induction areas) to assess impacts and identify needs.

The CO-S-TR framework, illustrated in Figure 2, is a tool to ensure key functions under ICS sections (CO – Command, S – Logistics, and TR – Operations) are being addressed in the early phase of an incident.

Figure 2. CO-S-TR Guide to Initial Incident Actions.[7]



Incident action planning is one of the most critical ICS principles, yet it is often underutilized in health care because most incidents last only 12-24 hours. Developing an Incident Action Plan (IAP) and setting operational period objectives are essential for aligning strategies and tactics toward defined goals. This process shifts the response from reactive to proactive, ensuring

[7] https://files.asprtracie.hhs.gov/documents/co-st-r-guide.pdf

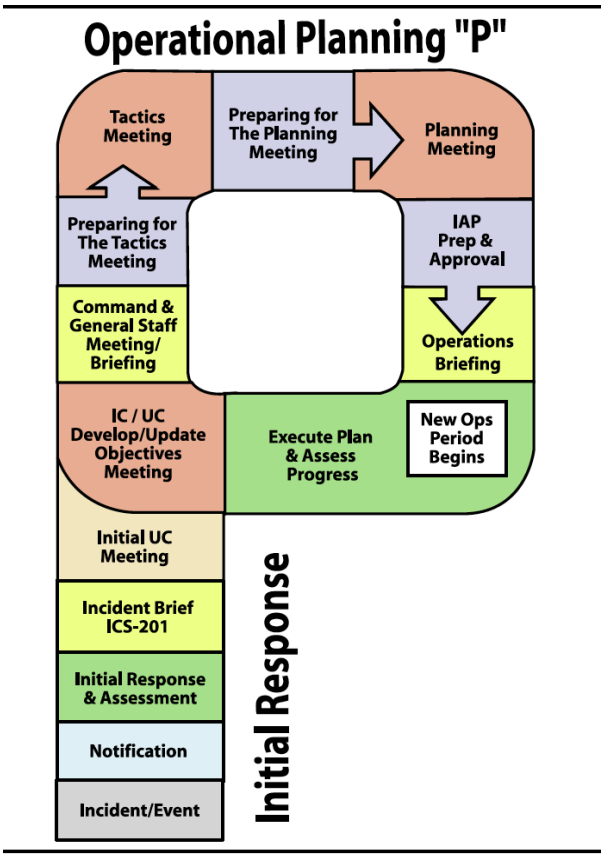
coordinated and purposeful action. Objectives for the first operational period often consist of the following:

- Obtaining incident information (i.e., situational awareness).
- Preventing incident expansion/incident stabilization (e.g., contain the scope, secure facility perimeter) and determining defensive/offensive strategies.
- Preventing harm to responders, patients, and visitors.
- Identifying/managing resource needs.
- Messaging, both internally and externally.
- Protecting the environment.

These objectives guide ICS during the first operational period or until they are met. Information gathered during this time helps inform the objectives for the next operational period.

Though hospitals may not rigidly follow the Planning "P" shown in Figure 3 it is an important conceptual framework for why operational periods and ICS Sections are important contributors to a proactive response.[8]

Figure 3. Planning "P".9



[8] ICS-201 in the figure refers to a standard initial incident briefing form that documents the situation and initial actions.

[9] National Incident Management System (NIMS) Planning P.

Formal ICS implementation sometimes requires lengthy IAPs, situational assessments, and other documents that may not be practical for frontline staff or leadership. Hospitals should maintain a standard template for incident documentation while working with the PIO on concise, bulleted summaries of objectives, updates, and changes that can be quickly distributed, understood, and acted on.[10] More detailed documentation should be reserved for the Planning Section and related functions. Additionally, a handoff template can help ensure continuity when the Command and General Staff transition.

Once Command Staff are confident that initial incident actions are appropriate, the Planning Section Chief and Incident Commander should establish the operational cadence (i.e., determine when the next operational period will begin). Ideally, this schedule should align with shift changes or relief staffing. The Planning Section Chief should:

- Ensure current actions are documented accurately and in a timely manner.
- Collaborate with the Incident Commander to set objectives for the next operational period. Examples may include staffing for the following day or adjusting surgical schedules to accommodate ongoing incident needs.
- Develop an IAP for the next operational period.

For prolonged incidents, a day/night Incident Commander rotation may be necessary. For lower intensity incidents, maintaining a single Incident Commander during daytime hours for an entire week may be appropriate.

Resource Management

In the fire service, all resource requests flow through the Logistics Section. In hospitals, units typically request supplies directly from departments such as pharmacy or the storeroom. If a decision or resource request can be resolved at the unit level using existing processes, those processes should be followed rather than introducing new ones during an incident.

Novel needs and decisions should be communicated to the Hospital Command Center, as they are likely to recur or affect multiple units. Providing early notice of these incident-driven demands helps anticipate and meet future needs. In some cases, the ICS staff in the Hospital Command Center may need to make allocation decisions (e.g., when staffing or supply requests exceed availability). Staffing often requires early Hospital Command Center staff involvement, as multiple units may need additional personnel. Determining how many staff to deploy and in what roles often requires leadership input and labor pool coordination.

Replenishment of supplies, obtaining additional supplies from distributors and other facilities, obtaining and onboarding (including emergency credentialing) supplemental staff, facilitating delivery of supplies during a disaster, obtaining community or contract-based resources (e.g.,

[10] The HICS IAP Quick Start combines HICS forms 201, 202, 203, 204, and 215A. It can serve as a substitute for complete ICS forms when managing a brief incident or to record early actions before transitioning to the complete ICS forms if the situation expands.

water, staffing), and many other resource decisions must be made. A strong Logistics Section Chief who can anticipate needs and creatively identify solutions can prevent or limit crisis conditions, particularly in protracted incidents.

Planning, Training, and Exercising

Effective use of ICS depends on consistent planning, resources, training, exercises, and regular application. Planning should involve both the units likely to be impacted during various types of incidents – ranging from utility failures to MCIs to electronic health record outages – and the Hospital Command Center staff.

The emergency manager should collaborate with primary response areas in the hospital to identify the supplies, policies, checklists, and training needed to initiate a response effectively at any time of day. Staff should be familiar with these resources, and exercises should be incorporated to practice their use and to reinforce preparedness. Staff should also practice the process for requesting additional support and engaging the Hospital Command Center. A checklist for activating the physical or virtual Hospital Command Center is recommended to ensure readiness when experienced personnel are not onsite. Additionally, a summary of the ICS structure and expectations for specific care areas and disciplines should be available in the Hospital Command Center.

From the Field

Many hospitals struggled with ICS during the COVID-19 pandemic for several reasons:

- The prolonged duration of the incident with multiple waves made decisions regarding demobilization of ICS and reactivation difficult.
- A fully scaled ICS could not be maintained.
- ICS often created parallels in decision-making with daily processes and sometimes resulted in paralysis when problems were identified and simply deferred to ICS where they were inadequately addressed.
- ICS was not integrated adequately with clinical care, resulting in situations where PPE or care was being rationed without a systematic approach.
- ICS was not granted authority to control scheduling of procedures, staffing ratios, or other key elements of the response, thus limiting effectiveness of strategies.

During unit-level planning and development, the emergency manager should emphasize the importance of personnel taking appropriate actions to adapt to evolving circumstances. A rigid application of ICS can lead to delays if unit staff defer time-sensitive decisions up the chain of command, potentially resulting in adverse outcomes. Instead, the priority should be ensuring that both situational information and decisions are communicated promptly to Hospital Command Center staff, enabling them to provide additional support—whether material, policy, or operational—as needed.

To build proficiency in less stressful settings, organizations should normalize applying ICS during smaller incidents, planned activities, and projects (e.g., generator replacement). Incorporating ICS terminology—such as operational periods and IAPs—helps familiarize hospital leadership

with processes that can be leveraged during emergencies. This is not a replacement for the training and exercises essential to ensure leaders understand their roles and responsibilities during actual incidents.

The most effective training occurs through tabletop and functional exercises, facilitated by experienced emergency managers, with ample opportunities for questions and discussion. NIMS training courses are available in person and online. [11] The building block ICS-100 and ICS-200 courses, which are prerequisites for advanced federal or state training, provide foundational knowledge of ICS processes and terminology. These courses require minimal time investment and are worthwhile courses to introduce a broad range of hospital personnel to the basics of ICS. However, they do not address facility-specific operational processes or priorities, nor do they cover incident action planning. Advanced courses such as ICS-300 and above build on these concepts and are particularly valuable for emergency managers and those likely to serve in Planning Section or other leadership roles in the Hospital Command Center.

Some large hospitals and many health systems provide advanced ICS and incident response training to a core group of individuals, with a particular focus on Planning Section responsibilities. These individuals may be mobilized as a team who can provide support for ICS processes to an impacted facility. Having personnel who can advise the facility leadership on recommended actions and support the Incident Commander and Command and General Staff with IAP development, documentation, communication/information management support, and sometimes technical support (e.g., behavioral health) can both provide expert input to guide the response and help the affected hospital offload significant administrative burdens. Depending on the scope of activities and team configuration, this may mean deployment of a few or many individuals.

Demobilization

The Incident Commander should continually assess when it is appropriate to demobilize ICS. In many MCIs, it may be tempting to declare the incident over once the ED returns to normal operations. However, pressures on surgical services, inpatient units, staffing, scheduling, and additional factors—such as media inquiries and family support—often persist or even intensify at that point. ICS should only be demobilized after a comprehensive assessment of all affected areas. In most cases, the ICS structure can be scaled back as demands decrease, but full deactivation should be avoided until the response is truly complete.

As the incident concludes, the Planning and Finance/Administration Sections typically become more active, focusing on documentation, cost tracking, and capturing lessons learned. This information forms the foundation of the After-Action Review (AAR), which the emergency manager compiles. Ideally, components of the AAR are gathered during the incident, though time and staffing constraints may limit this. The AAR should provide an overview of the

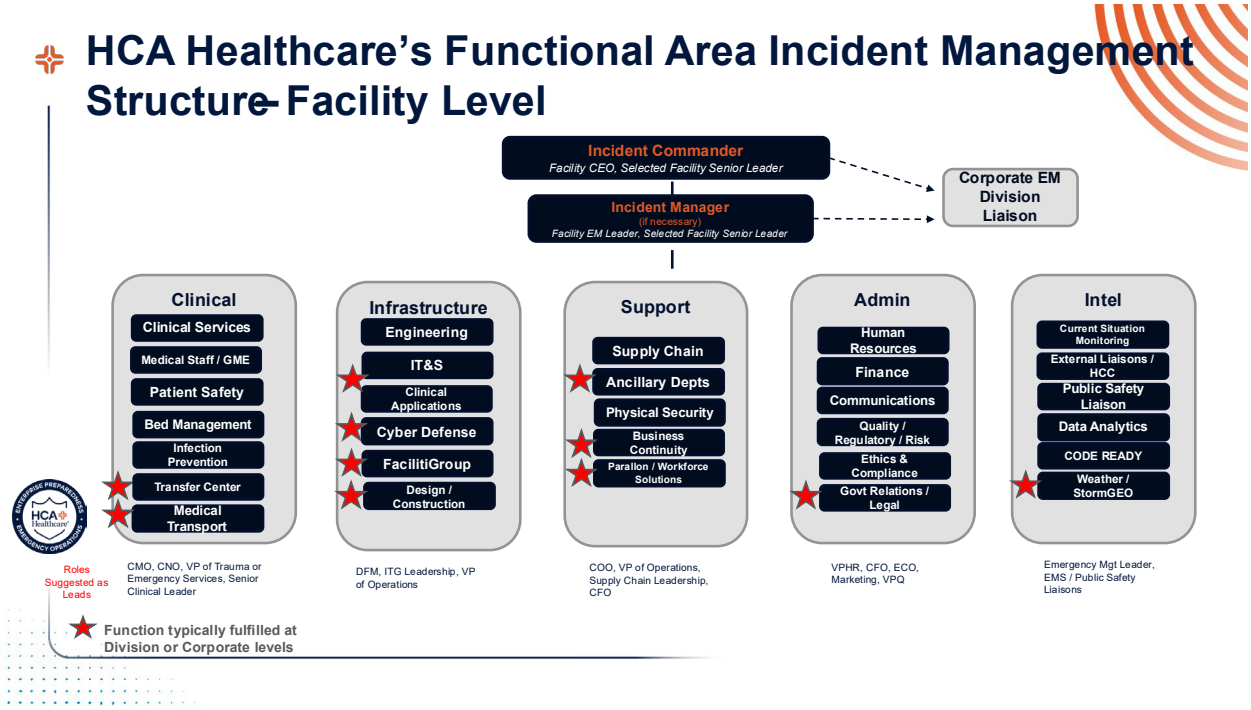
[11] Additional information about online independent study and in-person training may be found at https://training.fema.gov/ndemu/curriculum/.

incident, highlight strengths and areas for improvement, and document resources utilized. The emergency manager then uses the AAR to develop an Improvement Plan aimed at addressing gaps identified during the incident or exercise to strengthen future preparedness. The AAR also becomes a legal document that attests to the hospital's response to the incident.

Other Hospital Adaptations

Some hospitals and health systems have adopted a functional-area approach to ICS that retains key structural elements while aligning more closely with daily operations. An example of this structure used by a national multi-hospital system is shown in Figure 4. This model incorporates many corporate-level resources (indicated by a star symbol), which must be coordinated with local and regional assets. It also acknowledges that the individual with ultimate authority—such as the Chief Executive Officer—may not be the best person to manage the incident. In these cases, an Incident Manager may be designated under the Incident Commander. While this approach does not align with NIMS structure, it reflects practical realities; for example, a Chief Financial Officer with administrative authority may not be the ideal person to direct a hospital evacuation.

Figure 4. HCA Healthcare Incident Command Model (used with permission from HCA)



Some health systems also distinguish between the facility-level Incident Manager and a corporate incident command team. Depending on the health system, this corporate level team may exist to support the facility decision-making (similar to an EOC) or it may act more like a

Unified Command model (where the corporate team is actively making command-level decisions and identifying objectives and strategies with the facility).

Mount Sinai Health System's adaptation preserves Hospital Command Center and ICS/Unified Command functions but eliminates the typical ICS framework. Instead, there are two major branches of operations comprised of Clinical Support Functions (with Ambulatory Operations, Emergency Medicine, Nursing, and Radiology as examples of functional areas) and Essential Support Functions (with Ancillary Support Services, Communications and Marketing, and Real Estate, Facilities, and Engineering as examples of functional areas. In essence, this model duplicates the normal operations structure of the organization, with nuances that direct reporting and responsibility during the crisis or emergency. When required, task forces are implemented to bring affected cross-sector support functions together to solve specific/unique operational or logistical issues. This structure eliminates the sometimes-problematic distinction between Logistics and Operations roles.

In systems that use a top-down approach to ICS, unit-level requirements for supplies, job aids, and training remain unchanged, but the Hospital Command Center staff may have a more limited role, with Planning, Logistics, and Finance/Administration functions handled at the system level—leaving the hospital primarily focused on Operations.

Roles, responsibilities, and interactions between facility and health system command centers must be clearly defined and practiced. Technology can enable a hybrid command center that integrates system-level resources with facility-level information and response efforts. However, contingency plans are essential for technology or support failures, as over-reliance on external resources can put the hospital, staff, and patients at risk.

Conclusion

Effective hospital emergency response relies on the successful use of incident management principles. A key responsibility of the hospital emergency manager is ensuring the hospital implements an ICS structure tailored to its needs and that staff are adequately trained for their roles – both during the initial reactive phase and later proactive phase when the Hospital Command Center is fully operational. ICS provides a scalable, standardized framework for management, strategic direction, communication, and resource coordination, promoting an organized and safe response. Supporting early unit-level decision-making, followed by proactive coordination through the Hospital Command Center, creates a balanced approach. Each hospital department brings unique capabilities, resources, and priorities that should be anticipated and leveraged, and the emergency manager must ensure these areas are prepared to act and integrate effectively within the ICS structure.

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