ESF 8: PUBLIC HEALTH AND MEDICAL SERVICES

Emergency Support Function (ESF) #8 – Public Health and Medical Services provides the mechanism for coordination in response to a disaster, emergency, or incident that may lead to a public health, medical, behavioral, or human service emergency.

Coordinating Agencies	MARC: RHSCC - Public Health Subcommittee MARC: RHSCC - Hospital Subcommittee Kansas City Mortuary Operational Response Group (KCRMORG) MARC: Emergency Rescue Committee (MARCER) MARC: Metropolitan Emergency Managers Committee (MEMC) MOHAKCA Kansas (KS) - Kansas City Region Healthcare Coalition (KS-KCRHCC)
Cooperating Agencies	Local Public Health Agencies Medical/Healthcare Organizations [i.e. Hospitals, Federally Qualified Health Centers (FQHCs)] Local Emergency Medical Services (EMS) Local Long-term Care Facilities MARC: RHSCC - Mental Health and Functional and Access Needs Subcommittee Medical Reserve Corps of Greater Kansas City MARC: Environmental Health Work Group Local Medical Examiner or Coroner (ME/C) Local Funeral Homes Health Alliance of Mid-America KC Regional VOAD MARC: RHSCC – Law Enforcement Subcommittee School Districts Government Departments and Agencies Assigned Responsibilities in Local Emergency Operations Plans (EOPs) Others as Needed and Assigned in Local Emergency Operations Plans (EOPs)
State and Federal Agencies	Kansas Department of Health and Environment (KDHE) Missouri Department of Health and Senior Services (DHSS) Kansas Division of Emergency Management (KDEM) Missouri State Emergency Management Agency (SEMA) State Funeral Associations DHS: Federal Emergency Management Agency (FEMA) Department of Health and Human Services (HHS) Center for Disease Control and Prevention (CDC) Office of the Assistant Secretary for Preparedness and Response (ASPR) Others as Needed and Assigned in State and Federal Emergency Plans

Agency roles are described in Section VI – Responsibilities

Note: "Coordinating Agencies" and "Cooperating Agencies" may include committees that are comprised of multiple agencies/organizations.

COMPLIANCE NOTE: *CPG-101 version 2 indicates the following for all "support annexes" and documents: "for consistency, the recommended structure for all annexes is the same as that of the basic plan." (page 3-15 of CPG-101 vs. 2). In order to eliminate unnecessary redundancy, the ESFs include only those sections that have direct application and relevance to each respective support function. Sections that are not included in each of the ESFs (e.g. Introductory Materials; Admin, Finance, and Logistics; and Plan Development and Maintenance) are addressed in the Base Guide section of the Regional Coordination Guide.*

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I. PURPOSE

A. This Emergency Support Function (ESF) Annex to the Regional Coordination Guide (RCG) describes the coordination of available public health and medical services capabilities in the Kansas City metropolitan area.

B. ESF #8 is designed to accomplish the following: develop the necessary capabilities to achieve the first lines of response to bioterrorism, pandemic influenza, mass fatalities and other public health emergencies requiring a coordinated response from multiple jurisdictions and facilities. The ability to administer mass prophylaxis, triage and provide decontamination when necessary is essential. Emergency-ready hospitals and other healthcare entities must be able to work collectively to handle different types of injuries, infectious disease or chemical- or radiation-induced injuries and be ready to immediately accommodate an influx of supplemental healthcare assets from mutual-aid partners, States, and the Federal Government.

C. For more information on overall regional coordination activities, see the **RCG Base Guide** and the summary of key regional coordination concepts included as **Attachment A**.

II. SCOPE

A. RCG: ESF #8 is a functional component of the RCG, which consists of a Base Guide and fifteen (15) ESFs (for more information, see the RCG Base Guide). To the extent possible, information contained in other sections of the RCG will be referenced, not repeated in ESF #8.

B. RCG: ESF #8 provides a flexible organizational structure capable of meeting the varied requirements of different emergency scenarios with the potential to require multi-jurisdictional coordination in support of public health and medical services activities. Such emergency scenarios are described in the RCG Base Guide and summarized in **Attachment A.**

C. RCG: ESF #8 does not supersede the plans, policies and protocols maintained by local jurisdictions in the metropolitan area. Rather, the information in ESF #8 is designed to assist local jurisdictions when local resources are inadequate or when the event has regional significance.

D. The extent of coordination activities required in support of ESF #8 activities will depend on the capabilities of the jurisdictions and organizations involved and the type and scope of the incident.

E. ESF #8 includes 16 primary functions. Each one has its own separate concept of operations:

1. Activation and Emergency Operations Coordination
2. Information Sharing
3. Emergency Public Information
4. Medical surge
5. Triage and pre-hospital treatment
6. Medical Materiel Management and Distribution
7. Medical Countermeasure Dispensing
8. Public Health Laboratory Testing

9. Non-Pharmaceutical Interventions
10. Public Health Surveillance and Epidemiological Investigation
11. Fatality Management
12. Responder Safety and Health
13. Critical Healthcare Facility Protection
14. Mental/behavioral Healthcare
15. Environmental Health
16. Recovery

The following functions, although integral to ESF #8, are addressed in other ESFs within the RCG.

Table 1: Related ESF Activities

ESF 8 Function/Activity	Addressed in the Corresponding RCG: ESF
Emergency Public Information and Warning	ESF #15 – Emergency Public Information
Mass Care	ESF #6 – Mass Care, Emergency Assistance, Temporary Housing & Human Services
Volunteer Management	ESF #6 – Mass Care, Emergency Assistance, Temporary Housing & Human Services
Community Recovery	ESF #14 – Community Recovery

F. ESF #8 will address or reference, where appropriate, the following Core Capabilities and desired outcomes associated with ESF #8 related activities. It incorporates the region's 2014 Threat and Hazard Identification and Risk Assessment (THIRA). The THIRA evaluated the region's threats, hazards, and capabilities against the Core Capabilities outlined in the National Preparedness Goals.

The Regional THIRA expands on existing local and multi-state Hazard Identification and Risk Assessments (HIRAs) and other risk methodologies by broadening the factors considered in the process, incorporating the whole community throughout the entire process and by accounting for important community-specific factors. A copy of the THIRA may be obtained from MARC.

Table 2: ESF 8 Core Capabilities

CORE CAPABILITY	ESF #8 - OUTCOMES	OTHER REGIONAL PLANS AND ESFs
Public Information and Warning ***2014 KC THIRA Desired Outcomes, as applicable:*** *All local jurisdictions have the ability to deliver prompt, reliable and actionable information to impacted populations in accessible formats based on their local demographics, taking into account functional and access needs, and coordinate with other jurisdictions for consistent regional messaging.*	**PHP-** **Capability 4: Emergency Public Information and Warning** • At the time of an incident, coordinate with Public Information Officers, support staff, spokesperson(s), and subject matter experts throughout the Region. • At the time of an incident, assemble public information personnel (as needed) at the RHCC or virtual location. Debrief on incident, and assign response duties, as appropriate. • Assist local public health systems in implementing emergency communication abilities, as needed.	ESF 15 - Emergency Public Information

CORE CAPABILITY	ESF #8 - OUTCOMES	OTHER REGIONAL PLANS AND ESFs
	• As applicable to the incident, support a Virtual Joint Information Center for the Region, if establishment of a full-fledged Joint Information Center is not optimal. • Coordinate release of information for health and healthcare issues throughout the Region. • Develop, recommend, and execute approved public information plans and strategies on behalf of ESF 8. • Coordinate mechanisms (e.g., call center, poison control center, and non-emergency line) for public and media inquiries that can be scalable to meet the needs of the incident. • Prior to the incident, recognize established jurisdictional legal guidelines to avoid communication of information that is protected for national security or law enforcement reasons or that may infringe on individual and entity rights. • Coordinate the dissemination of information to the public, and support the following: languages and formats that take into account jurisdiction demographics, at-risk populations, economic disadvantages, limited language proficiency, and cultural or geographical isolation. • Coordinate health-related messaging information to responder organizations through secure messaging platforms. **Capability 6: Information Sharing** • Prior to and as necessary during an incident, identify the following to determine information sharing needs: o intra-regional stakeholders across public health, public safety, private sector, law enforcement, and other disciplines • Prior to and as necessary during an incident, work with elected officials, identified stakeholders and private sector	Regional Healthcare Coordination Guide

CORE CAPABILITY	ESF #8 - OUTCOMES	OTHER REGIONAL PLANS AND ESFs
	leadership to promote and ensure continual connection (e.g., ongoing standing meetings, webinars, and teleconferences) and use continuous quality improvement process to define and redefine information-sharing needs. **HPP-** **Capability 6: Information Sharing** • Before an incident, identify the essential elements of incident specific healthcare information that are timely, relevant, actionable, and can be reasonably delivered during the response • Before, during, and after an incident, utilize coordinated information sharing protocols to receive and transmit timely, relevant, and actionable incident specific healthcare information to incident management during response and recovery • Before, during, and after an incident or event, have redundant processes and systems to communicate: o with the appropriate multijurisdictional and multidisciplinary emergency responders o the status of the incident and the status of the community healthcare delivery to healthcare organizations	
Critical Transportation ***2014 KC THIRA Desired Outcomes, as applicable:*** *Within 90 minutes of an incident, assess and initiate transportation response priority objectives to provide transportation (including accessible transportation services) for response priority objectives, including the evacuation of people and animals and the delivery of vital response personnel, equipment and services into affected areas by identifying transportation*	**PHP-** **Capability 9: Medical Materiel Management and Distribution** • Prior to an incident, identify transportation assets from commercial and/or government sources and create a transportation asset list. • Prior to and when applicable during an incident, identify and coordinate with medical materiel suppliers and distributors within the region to assess resource availability and potential distribution challenges • During an incident coordinate transportation assets from pre-identified asset list, dependent on incident needs. **Capability 10: Medical Surge**	ESF 1 – Transportation MARCER MCI Plan

CORE CAPABILITY	ESF #8 - OUTCOMES	OTHER REGIONAL PLANS AND ESFs
resources within the nine-county area prior to a disaster. Identify the need for and request resources from normal mutual aid partners, regional partners and state resources. *Establish physical access through appropriate transportation corridors within eight hours for emergency response. Within one hour, identify the need for and request resources from normal mutual aid partners, regional partners and state resources.*	• During an incident, coordinate with jurisdictional partners and healthcare coalitions to facilitate patient tracking during all phases of the incident. **HPP-** **Capability 6: Information Sharing** • Before, during, and after an incident or event, have redundant processes and systems to communicate: o with the appropriate multijurisdictional and multidisciplinary emergency responders o the status of the incident and the status of the community healthcare delivery to healthcare organizations	
Environmental Response/Health and Safety	**PHP-** **Capability 14: Responder Health and Safety** • Participate in the formulation of recommendations regarding responder-specific risks to be addressed in incident action plans. • Coordinate the distribution of safety materiels to public health responders. • Coordinate with regional partners to provide medical countermeasures and/or personal protective equipment to public health responders, if indicated by the incident. • Coordinate with healthcare partners to facilitate access to and promote the availability of medical and mental/behavioral health services for responders, either on-site or off-site as applicable to the incident. • Provide guidance to partner organizations to help conduct monitoring of any responder staff for medical/mental/behavioral incident-related health outcomes. • Utilize surveillance data and other applicable inputs from partner agencies to provide recommendations or considerations for any changes related to the use of personal protective equipment	ESF 10 – Oil & Hazardous Materials

CORE CAPABILITY	ESF #8 - OUTCOMES	OTHER REGIONAL PLANS AND ESFs
	(e.g., to alter, suspend, or terminate any activity or personal protective equipment usage judged to improve the outcome or be an imminent danger or immediately dangerous to life and health). **HPP-** **Capability 14: Responder Health and Safety** • Help to identify the PPE required to protect healthcare workers during exposure incidents based on risk assessments, HVAs, and resource needs.	
Public Health and Medical Services ***2014 KC THIRA Desired Outcomes, as applicable:*** *Within one hour of credible evidence of the presence of Category "A" infectious diseases, 100 percent of LPHA/LHD's activate Public Health Incident Management Teams to activate response plans, notify health care partners, request SNS, and initiate epidemiological investigation to determine target population due to primary and secondary exposures.* *Within 48 hours of notification of potential public health emergency 100 percent of LPHA/LHDs conduct enhanced public health surveillance to identify potential cases.* *Within one hour of identification of potential case(s), initiate epidemiological investigation to create, maintain, support, and strengthen routine surveillance and detection systems and epidemiological investigation processes, as well as to expand these systems and processes in response to incidents of public health significance.* *Within 48 hours of the decision to dispense medical countermeasures, receive,*	**PHP-** **Capability 3: Emergency Operations Coordination** • In preparation for or at the time of an event or incident, assemble designated personnel at the RHCC. • Maintain regional situational awareness using information gathered from medical, public health, and other health stakeholders. **Capability 8: Medical Countermeasure Dispensing** • Prior to an incident, and if applicable during an incident, engage subject matter experts (e.g., epidemiology, laboratory, radiological, chemical, and biological) including federal partners, to determine what medical countermeasures are best suited and available for the incidents most likely to occur in the Region based on jurisdictional risk assessment. **Capability 11: Non-Pharmaceutical Interventions** • Prior to an incident, engage healthcare organizations, government agencies, and community sectors (e.g., education, social services, faith-based, business, and legal) in coordinating and defining roles and responsibilities in non-pharmaceutical interventions on an ongoing basis through multidisciplinary meetings. • At the time of the incident, assemble subject matter experts to assess the severity of exposure and/or transmission at the regional level, and determine non-pharmaceutical intervention recommendations.	MARCER MCI Plan RHCS Guide Regional Mental Health Response System Plan

CORE CAPABILITY	ESF #8 - OUTCOMES	OTHER REGIONAL PLANS AND ESFs
distribute and dispense mass medical countermeasures for public health emergencies to target [potentially exposed] populations. *Within 24 hours of identification/notification of infectious disease within the region, 100 percent of LPHA/LHDs recommend and implement initial strategies for infectious disease exposure control.* *Conduct regional medical surge to increase hospital bed availability to 20 percent above normal capacity.* ***2014 KC THIRA Desired Outcomes, as applicable:*** *In four hours, complete triage, initial stabilization, transport and tracking of casualties and begin definitive care for those likely to survive their injuries.*	• At the time of an incident, assist regional partners with coordinating support services (e.g., medical care and mental health) to individuals included in non-pharmaceutical intervention(s). • At the time of an incident, assist in educating and informing the public, response agencies and other partners regarding the recommended intervention(s), as needed. • Disseminate regional situational awareness reports on impact of the intervention to all agencies involved in the intervention(s).	
Fatality Management Services ***2014 KC THIRA Desired Outcomes, as applicable:*** *Within 24 hours of fatality notifications, initiate the safe recovery, receipt, identification, decontamination, transportation, storage and disposal of large numbers of human remains to include an assessment of the need for temporary burial, procurement of public property for temporary burial and security/privacy requirements of the processing facility.*	**PHP-** **Capability 5: Fatality Management** • Coordinate with partners to identify and assemble the resources required to collect and communicate antemortem data. • Coordinate with partners and assist, if needed, in the collection and dissemination of antemortem data to families of the deceased and law enforcement officials. • Coordinate with partners to support electronic recording and reporting of antemortem data through electronic systems and/or other information sharing platforms. • Coordinate with partners to assemble the required staff and resources to provide non-intrusive mental/behavioral health services to responders.	Regional Mass Fatality Plan

CORE CAPABILITY	ESF #8 - OUTCOMES	OTHER REGIONAL PLANS AND ESFs
	• Coordinate with partners to facilitate availability of culturally appropriate assistance (e.g., addressing language barriers and religious or cultural practices). • Coordinate with partners to support the provision of mental/behavioral health services to family members of the deceased and incident survivors as needed. • Make recommendations to incident management/jurisdictional lead agency on procedures for the safe recovery, receipt, identification, decontamination, transportation, storage, and disposal of human remains. Recommendations can also include an assessment of the need for temporary burial, procurement of public property for temporary burial, and security/privacy requirements of the processing facility. • Coordinate with partners to support electronic death reporting. • Coordinate with partners to facilitate the collection and reporting of mortality information (e.g., vital records). **HPP-** **Capability 5: Fatality Management** • Prior to an incident, assist healthcare organizations with determining the amount of morgue space that is available to them during periods of death surges and develop the processes to request support from local and state agencies. • Prior to an incident, coordinate with healthcare organizations to identify alternate storage and disposal options for human remains • Prior to an incident, assist healthcare organizations by coordinating options for surges of concerned citizens and their direction to the appropriate location for family assistance when these surges arrive at the facility seeking family member information	

CORE CAPABILITY	ESF #8 - OUTCOMES	OTHER REGIONAL PLANS AND ESFs
	• Coordinate the options for mental/Behavioral support for healthcare organizations during disasters which cause a death surge involving a large amount of human remains	
Mass Care Services ***2014 KC THIRA Desired Outcomes, as applicable:*** *Within 12 hours, establish, staff, and equip emergency shelters to provide Mass Care services, including functional needs support services, collectively for 100% shelter seeking population.* *Within 12 hours, provide pet sheltering for 10% of impacted owners' pets.* *Within 24 hours, implement a comprehensive feeding strategy to provide 3 meals/day to shelter residents, impacted population, volunteers, and emergency responders.* *Within 2 days, coordinate with community partners to provide support services to begin to transition shelter clients from emergency shelters to non-congregate care alternatives and provide relocation assistance or interim housing solutions for families unable to return to their pre-disaster homes.* *Within 24 hours, develop and begin implementation of a comprehensive donations and volunteer management plan.* **Health and Social Services** ***2012 KC THIRA Desired Outcomes, as applicable:***	**PHP-** **Capability 7: Mass Care** • At the time of an incident, coordinate pre-determined public health roles (e.g., population monitoring, environmental health and safety assessment, accessibility for populations with special needs, and need for decontamination) needed in the mass care response in coordination with Emergency Support Function #6 and #8 partners. • At the time of an incident, coordinate with response partners to utilize pre-existing jurisdictional risk assessment, environmental data, and health demographic data to identify population health needs in the area impacted by the incident. • At the time of an incident, coordinate with response partners to complete a facility-specific environmental health and safety assessment of the selected or potential congregate locations. • During the incident, coordinate with partner agencies to ensure food and water safety inspections at congregate locations. • During the incident, coordinate with partners to ensure health screening of the population registering at congregate locations. • At the time of the incident, coordinate with healthcare partners to ensure medical and mental/behavioral health services are accessible at or through congregate locations. • At the time of the incident, coordinate with providers to facilitate access to medication and assistive devices for individuals impacted by the incident.	ESF #6 - Mass Care, Emergency Services, Temporary Housing, and Human Services

CORE CAPABILITY	ESF #8 - OUTCOMES	OTHER REGIONAL PLANS AND ESFs
By D+14, complete an assessment of community health and social service needs and develop a comprehensive recovery timeline. *By D+60, restore basic health and social services functions. Identify critical areas of need for health and social services, as well as key partners and at-risk individuals (such as children, those with disabilities and others who have access and functional needs, and populations with limited English proficiency) in short-term, intermediate, and long-term recovery.*	• At the time of the incident, if applicable, coordinate with jurisdictional HazMat resources or other lead agencies to ensure provision of population monitoring and decontamination services, including the establishment of tracking systems of contaminated or possibly contaminated (e.g., radiological, nuclear, or chemical) individuals who may enter congregate locations. • During an incident, disseminate and promote accessible information regarding available mass care health services to the public. • During an incident, coordinate with agencies to accommodate and provide care (e.g., medical care, essential needs, and decontamination) for service animals within general shelter populations. • At the time of the incident, work with partner agencies in coordinating the location of human sheltering efforts with household pet sheltering efforts. • During and after an incident, coordinate with emergency medical services, local, state, tribal, and federal health agencies, emergency management agencies, state hospital associations, social services, and participating non-governmental organizations to return individuals displaced by the incident to their pre-incident medical environment (e.g., prior medical care provider, skilled nursing facility, or place of residence) or other applicable medical setting. • During an incident, in coordination with partner agencies, monitor facility-specific environmental health and safety, including screening for contamination (e.g., radiological, nuclear, biological, or chemical), and ensure any identified deficiencies are corrected. • During an incident, coordinate surveillance at congregate locations to identify cases of illness, injury, and exposure within mass care populations.	

CORE CAPABILITY	ESF #8 - OUTCOMES	OTHER REGIONAL PLANS AND ESFs
	• During an incident, identify updated health needs as part of the Region's situational awareness update. • After an incident, in conjunction with partner agencies, de-escalate health response as appropriate to the mass care situation, including creating and executing a health resource demobilization plan.	
Public and Private Services and Resources ***2012 KC THIRA Desired Outcomes, as applicable:*** *Within 24 hours, mobilize and deliver governmental, nongovernmental, and private sector resources within and outside of the affected area to save lives, sustain lives, meet basic human needs, stabilize the incident, and transition to recovery, to include moving and delivering resources and services to meet the needs of disaster survivors.*	**PHP-** **Capability 10: Medical Surge** • At the time of an incident, participate in a unified incident management structure. • During an incident, coordinate information to educate the public, paying special attention to the needs of at-risk individuals (e.g., information is linguistically appropriate, culturally sensitive, and sensitive to varied literacy levels) regarding changes to the availability of healthcare services. • During an incident, coordinate and maintain communications throughout the incident per jurisdictional authority/jurisdictional incident management structure with federal, state, local, and non-governmental agencies; private sector agencies; and other Emergency Support Function #8 partners to maintain situational awareness of the actions of all parties involved, determine needs, and maintain continuity of services during response operations. **HPP-** **Capability 10: Medical Surge** • Develop a process for healthcare organizations to provide multi-agency coordination regarding resource decisions during medical surge operations	ESF #11 – Agriculture and Natural Resources ESF 7 - Logistics Regional Resource Annex

Table 3: Health and Medical Capabilities Assessment

	CORE CAPABILITIES *Department of Homeland Security (DHS) - April, 2012 (Date of CPG 201)*	TARGET CAPABILITIES LIST *Department of Homeland Security (DHS) - September, 2007*	PUBLIC HEALTH PREPAREDNESS CAPABILITIES: NATIONAL STANDARDS FOR STATE AND LOCAL PLANNING *Centers for Disease Control and Prevention (CDC) - March, 2011*	HEALTHCARE PREPAREDNESS CAPABILITIES: NATIONAL GUIDANCE FOR HEALTHCARE SYSTEM PREPAREDNESS *Hospital Preparedness Program (HPP) - January, 2012*
0. Capabilities Shared Across All Mission Areas				
0.1	Planning	Planning	Planning Resource Elements are included in each capability.	Planning Resource Elements are included in each capability.
0.2	Public Information and Warning	Emergency Public Information and Warning	Capability 4: Emergency Public Information and Warning	Capability 6: Information Sharing Function 1: Provide healthcare situational awareness that contributes to the incident common operating picture Resource Element P4: Healthcare information sharing with the public
0.3	Operational Coordination	Emergency Operations Center Management	Capability 3: Emergency Operations Coordination	Capability 3: Emergency Operations Coordination
		On-Site Incident Management	--	--
1. Prevention				
1.1	Forensics and Attribution	--	--	--
1.2	Intelligence and Information Sharing	Information Gathering and Recognition of Indicators and Warnings	--	--
		Intelligence Analysis and Production	--	--
		Intelligence and Information Sharing and Dissemination	Capability 6: Information Sharing	Capability 6: Information Sharing Function 1: Provide healthcare situation awareness that contributes to the incident common operating picture
1.3	Interdiction and Disruption	Counter-Terror Investigation and Law Enforcement	--	--
1.4	Screening, Search and Detection	CBRNE Detection	--	Capability 10: Medical Surge Function 2: Coordinate integrated healthcare surge operations with pre-hospital Emergency Medical Services (EMS) operations Resource Element S2: Coordinated CBRNE training

	CORE CAPABILITIES *Department of Homeland Security (DHS) - April, 2012 (Date of CPG 201)*	TARGET CAPABILITIES LIST *Department of Homeland Security (DHS) - September, 2007*	PUBLIC HEALTH PREPAREDNESS CAPABILITIES: NATIONAL STANDARDS FOR STATE AND LOCAL PLANNING *Centers for Disease Control and Prevention (CDC) - March, 2011*	HEALTHCARE PREPAREDNESS CAPABILITIES: NATIONAL GUIDANCE FOR HEALTHCARE SYSTEM PREPAREDNESS *Hospital Preparedness Program (HPP) - January, 2012*
2. Protection				
2.1	Access Control and Identity Verification	--	--	--
2.2	Cybersecurity	--	--	--
2.3	Intelligence and Information Sharing	Information Gathering and Recognition of Indicators and Warnings	--	--
		Intelligence Analysis and Production	--	--
		Intelligence and Information Sharing and Dissemination	Capability 6: Information Sharing	Capability 6: Information Sharing Function 1: Provide healthcare situation awareness that contributes to the incident common operating picture
2.4	Interdiction and Disruption	Counter-Terror Investigation and Law Enforcement	--	--
2.5	Physical Protective Measures	Critical Infrastructure Protection	--	--
2.6	Risk Management for Protection Programs and Activities	Risk Management	--	--
2.7	Screening, Search and Detection	CBRNE Detection	--	Capability 10: Medical Surge Function 2: Coordinate integrated healthcare surge operations with pre-hospital Emergency Medical Services (EMS) operations Resource Element S2: Coordinated CBRNE training
2.8	Supply Chain Integrity and Security	Animal Disease Emergency Support	--	--
		Food and Agriculture Safety and Defense	--	--
3. Mitigation				

	CORE CAPABILITIES *Department of Homeland Security (DHS) - April, 2012 (Date of CPG 201)*	TARGET CAPABILITIES LIST *Department of Homeland Security (DHS) - September, 2007*	PUBLIC HEALTH PREPAREDNESS CAPABILITIES: NATIONAL STANDARDS FOR STATE AND LOCAL PLANNING *Centers for Disease Control and Prevention (CDC) - March, 2011*	HEALTHCARE PREPAREDNESS CAPABILITIES: NATIONAL GUIDANCE FOR HEALTHCARE SYSTEM PREPAREDNESS *Hospital Preparedness Program (HPP) - January, 2012*
3.1	Community Resilience	Community Preparedness and Participation	Capability 1: Community Preparedness	Capability 1: Healthcare system preparedness
3.2	Long-term Vulnerability Reduction	--	--	--
3.3	Risk and Disaster Resilience Assessment	--	--	--
3.4	Threats and Hazard Identification	--	--	--
		4. Response		
4.1	Critical Transportation	Citizen Evacuation and Shelter-in-Place	--	Capability 10: Medical Surge Function 5: Provide assistance to healthcare organizations regarding evacuation and shelter in place operations
4.2	Environmental Response/Health and Safety	Environmental Health	--	--
		Responder Safety and Health	Capability 14: Responder Safety and Health	Capability 14: Responder Safety and Health
		WMD and Hazardous Materials Response and Decontamination	--	--
4.3	Fatality Management Services	Fatality Management	Capability 5: Fatality Management	Capability 5: Fatality Management
4.4	Infrastructure Systems	Restoration of Lifelines	--	--
		Structural Damage Assessment	--	--
4.5	Mass Care Services	Mass Care (Sheltering, Feeding, and Related Services)	Capability 7: Mass Care	--
4.6	Mass Search and Rescue Operations	Search and Rescue (Land-based)	--	--
4.7	On-Scene Security and Protection	Emergency Public Safety and Security Response	--	--

	CORE CAPABILITIES *Department of Homeland Security (DHS) - April, 2012 (Date of CPG 201)*	TARGET CAPABILITIES LIST *Department of Homeland Security (DHS) - September, 2007*	PUBLIC HEALTH PREPAREDNESS CAPABILITIES: NATIONAL STANDARDS FOR STATE AND LOCAL PLANNING *Centers for Disease Control and Prevention (CDC) - March, 2011*	HEALTHCARE PREPAREDNESS CAPABILITIES: NATIONAL GUIDANCE FOR HEALTHCARE SYSTEM PREPAREDNESS *Hospital Preparedness Program (HPP) - January, 2012*
		Explosive Device Response Operations (EDRO)	--	--
4.8	Operational Communications	Communications	--	Capability 6: Information Sharing Function 2: Develop, refine, and sustain redundant, interoperable communication systems
4.9	Public and Private Services and Resources	Critical Resource Logistics and Distribution	--	--
		Fire Incident Response Support	--	--
		Volunteer Management and Donations	Capability 15: Volunteer Management	Capability 15: Volunteer Management
4.10	Public Health and Medical Services	Emergency Triage and Pre-Hospital Treatment	--	Capability 10: Medical Surge Function 2: Coordinate integrated healthcare surge operations with pre-hospital Emergency Medical Services (EMS) operations Resource Element S1: Training on local EMS disaster triage methodologies
		Epidemiological Surveillance and Investigation	Capability 13: Public Health Surveillance and Epidemiological Investigation	--
		Isolation and Quarantine	Capability 11: Non-Pharmaceutical Interventions	--
		Laboratory Testing	Capability 12: Public Health Laboratory Testing	--
		Mass Prophylaxis	Capability 8: Medical Countermeasure Dispensing	--
		Medical Supplies Management and Distribution	Capability 9: Medical Materiel Management and Distribution	--
		Medical Surge	Capability 10: Medical Surge	Capability 10: Medical Surge
4.11	Situational Assessment	--	--	--

	CORE CAPABILITIES *Department of Homeland Security (DHS) - April, 2012 (Date of CPG 201)*	TARGET CAPABILITIES LIST *Department of Homeland Security (DHS) - September, 2007*	PUBLIC HEALTH PREPAREDNESS CAPABILITIES: NATIONAL STANDARDS FOR STATE AND LOCAL PLANNING *Centers for Disease Control and Prevention (CDC) - March, 2011*	HEALTHCARE PREPAREDNESS CAPABILITIES: NATIONAL GUIDANCE FOR HEALTHCARE SYSTEM PREPAREDNESS *Hospital Preparedness Program (HPP) - January, 2012*
5. Recovery				
5.1	Economic Recovery	Economic and Community Recovery	Capability 2: Community Recovery	Capability 2: Healthcare System Recovery
5.2	Health and Social Services	--	--	--
5.3	Housing	--	--	--
5.4	Natural and Cultural Resources	--	--	--

III. SITUATION OVERVIEW

A. The nine-county, bi-state region is served by over 30 major hospitals.

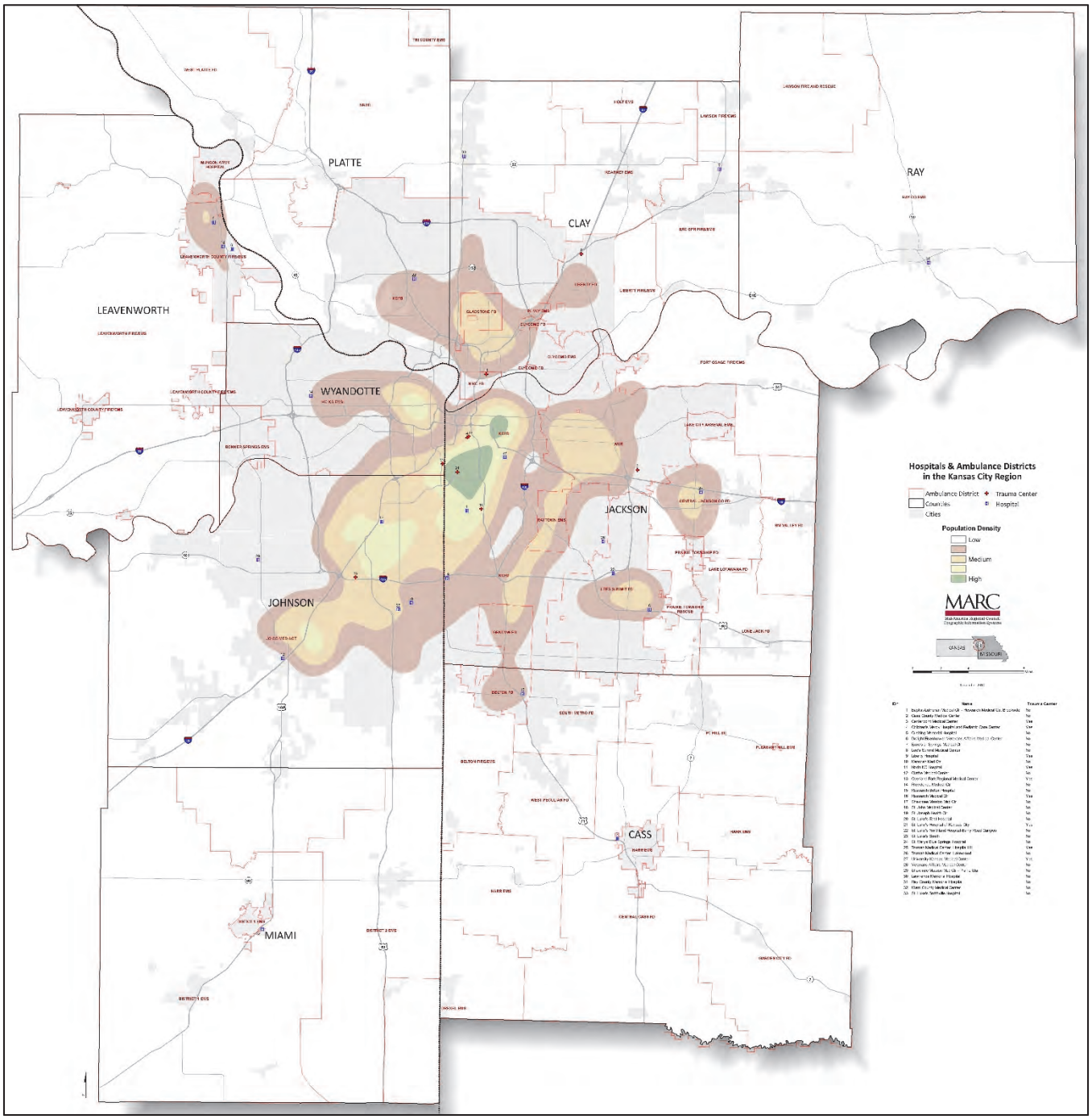
B. There are over 40 state-licensed EMS agencies, including, EMS departments, fire departments, air ambulance services and other providers.

Table 4. Hospitals in Kansas City UASI Region

HOSPITAL	CORPORATE SYSTEM	LOCAL HEALTH DEPARTMENT
KANSAS		
Children's Mercy South	Children's Mercy	Johnson County
Menorah Medical Center	HCA Midwest Health System	Johnson County
Olathe Medical Center	Olathe Health System	Johnson County
Overland Park Regional Medical Center	HCA Midwest Health System	Johnson County
Prairie Star	Adventist Health System	Johnson County
Saint Luke's South Hospital	St. Luke's Health System	Johnson County
Shawnee Mission Medical Center	Adventist Health System	Johnson County
St. Luke's Cushing Hospital	St. Luke's Health System	Leavenworth County
Saint John Hospital	Prime Healthcare	Leavenworth County
Providence Medical Center	Prime Healthcare	Wyandotte County
University of Kansas Hospital	N/A	Wyandotte County
HOSPITAL	**CORPORATE SYSTEM**	**LOCAL HEALTH DEPARTMENT**
MISSOURI		
Cass Regional Medical Center	N/A	Cass County
Research Belton Hospital	HCA Midwest Health System	Cass County
Excelsior Springs Medical Center	N/A	Clay County

Liberty Hospital	N/A	Clay County
North Kansas City Hospital	N/A	Clay County
St. Luke's North Hospital – Smithville	St. Luke's Health System	Clay County
Centerpoint Medical Center	HCA Midwest Health System	Independence, MO
Lee's Summit Hospital	HCA Midwest Health System	Jackson County
St. Luke's East Hospital	St. Luke's Health System	Jackson County
St. Mary's Medical Center	Carondelet Health	Jackson County
Children's Mercy Hospital	Children's Mercy	Kansas City, MO
Kindred Hospital of Kansas City	Kindred Healthcare	Kansas City, MO
Kindred Hospital North	Kindred Healthcare	Kansas City, MO
Research Medical Center	HCA Midwest Health System	Kansas City, MO
Research Medical Center – Brookside	HCA Midwest Health System	Kansas City, MO
Research Psychiatric Center	HCA Midwest Health System	Kansas City, MO
St. Joseph's Medical Center	Carondelet Health	Kansas City, MO
St. Luke's Hospital of Kansas City	St. Luke's Health System	Kansas City, MO
St. Luke's Hospital – Crittenton	St. Luke's Health System	Kansas City, MO
St. Luke's North Hospital – Barry Road	St. Luke's Health System	Kansas City, MO
The Rehabilitation Institute	N/A	Kansas City, MO
Truman Medical Center - Lakewood	Truman Medical Centers	Kansas City, MO
Truman Medical Center – Hospital Hill	Truman Medical Centers	Kansas City, MO
Two Rivers Behavioral Health System	N/A	Kansas City, MO
Veteran Affairs Medical Center	Federal Government	Kansas City, MO
Center for Behavioral Medicine (formerly Western Missouri Mental Health Center)	State Government	Kansas City, MO
Ray County Memorial Hospital	N/A	Ray County

Figure 1. Hospitals and Ambulance Districts



Authorities

State of Kansas

- K.S.A. 48-901a Interstate Emergency Management Assistance Compact;
- K.S.A. 48-904 et seq. K.S.A. 48-924 – 945 Emergency Preparedness for Disasters;
- K.S.A. 48-948 – K.S.A. 48-958 – Kansas Intrastate Emergency Mutual Aid Act;
- K.S.A. 65-Articles 1 and 2 Public Health System;
- K.S.A. 65-101 et seq. the secretary of health and environment shall exercise general supervision of the health of the people of the state;
- K.S.A 65-119a - Provides the duties and powers of local health officers;
- K.S.A. 65-201: defines "local board of health" and "local health officer"; and
- K.S.A. 65-5701 – 5731 EPCRA.

State of Missouri

- Missouri Revised Statues (RSMO), as amended, Chapter 44, defines the authority of the Chief Elected Official in each political subdivision to declare a state of emergency. This statute requires that each political subdivision have an Emergency Management organization and a local EOP.
- RSMO, as amended, Chapters 70, 192 and 205 provides the organization for local public health departments and gives the local Public Health Director the authority to declare a public health emergency and authorize measures to protect public health.
- RSMO, as amended, Chapter 44, Section 44.090, assigns political subdivisions in the state the responsibility for adopting NIMS as their emergency incident management system.

Federal

- Public Law 106-390, 114 Stat. 1552-1578 (1974) The Robert T. Stafford Disaster Relief and Emergency Assistance Act, as amended;
- Public Law 107-188, 116 Stat. 294 (2002) The Public Health Security and Bioterrorism Preparedness and Response Act of 2002;
- Public Law 107-296, 116 Stat. 2135 (2002) The Homeland Security Act of 2002;
- 10 U.S.C. 382 (2002) Emergencies Involving Chemical or Biological Weapons;
- 42 U.S.C. 201 et seq., The Public Health Service Act;
- 50 U.S.C. 1601-1651 (2003) The National Emergencies Act.
- The ***Health Information Portability and Accountability Act*** (HIPAA) includes provisions allowing the local health department to receive disease reports or laboratory test results from physicians and laboratory directors in an appropriate and timely manner.
- The Aviation Disaster Family Assistance Act of 1996, the National Transportation Safety Board has designated to the ARC the Coordinating responsibility for coordinating the emotional care and support of the families of passengers involved in an aviation accident.
- ***Pandemic and All-Hazards Preparedness Act*** (PAHPRA) is intended to improve the Nation's public health and medical preparedness and response capabilities for emergencies, whether deliberate, accidental, or natural. The Act was reauthorized in 2013.
- ***Public Readiness and Emergency Preparedness Act*** (PREP Act) authorizes the Secretary of the Department of Health and Human Services (Secretary) to issue a declaration (PREP Act declaration) that provides immunity from liability (except for willful misconduct) for claims of loss caused, arising out of, relating to, or resulting from administration or use of countermeasures to diseases, threats and conditions determined by the Secretary to constitute a present, or credible risk of a future public health emergency to entities and individuals involved in the development, manufacture, testing, distribution, administration, and use of such countermeasures. A PREP Act

declaration is specifically for the purpose of providing immunity from liability, and is different from, and not dependent on, other emergency declarations.

State & Federal Role in ESF #8 Activities

A. The State of Kansas and Missouri will provide assistance, as defined in their respective plans, to supplement local and regional resources in response to public health and medical care needs following a major disaster or emergency, or during a developing potential medical situation.

B. In a major public health or medical emergency, demand for public health and medical resources may exceed local, regional, and state capabilities. Kansas and/or Missouri may request assistance through the Emergency Management Assistance Compact (EMAC) or may request Federal assistance, which may be executed with or without a Stafford Act declaration.

C. If the event exceeds local and regional capabilities, there are state and federal assets that may be available to respond to a public health and medical emergency, such as the following:

- **Strategic National Stockpile (SNS)**

  The Strategic National Stockpile is a national repository of antibiotics, chemical antidotes, antitoxins, life-support medications, intravenous supplies, airway maintenance supplies, and medical and surgical items. The Strategic National Stockpile is designed to supplement and re-supply state and local public health agencies during any national emergency within the United States or its territories

  The Strategic National Stockpile is organized for flexible response. The first line of support is provided by immediate response 12-hour push packages, which are caches of pharmaceuticals, antidotes, and medical supplies designed to provide rapid delivery of a broad spectrum of assets for an ill-defined threat in the early hours of an incident. Push packages are positioned in strategically located, secure warehouses ready for immediate deployment to a designated site within 12 hours of the Federal decision to deploy Strategic National Stockpile assets

- **National Disaster Medical System (NDMS), including Disaster Medical Assistance Teams (DMATs) and Disaster Mortuary Operations Teams (DMORTs)**

  The National Disaster Medical System supplements state and local emergency medical response during a disaster or major emergency. The National Disaster Medical System is managed by ESF #8. The major components of the system are medical response, patient evacuation, and definitive medical care. The U.S. Department of Health and Human Services activates and deploys National Disaster Medical System health and medical personnel, equipment and supplies, outpatient services, veterinary services, and mortuary services. The U.S. Department of Health and Human Services coordinates with the Veterans Administration and the U.S. Department of Defense to evacuate patients from hospitals in affected areas and admit them in hospitals that participate in the National Disaster Medical System. The U.S. Department of Homeland Security, through ESF # 1 – Transportation, may arrange for the use of Federal agency aircraft and other assets to provide urgent care lift and other transportation support.

- **National Guard Weapons of Mass Destruction Civil Support Teams (CST)**
- **Regional Homeland Security Response Teams (HSRT)**
- **Other specialized State National Guard resources (e.g., air ambulance detachments, heavy equipment, etc.)**
- **Other federal resources may be available if the incident is isolated to the metro-area, such as one of the National Medical Response Teams (NMRTs)**

D. If the situation warrants, the appropriate state and federal resources will be requested through local EOCs based on advice from the IC/UC. The local EOC will contact the State EOC to formally request such resources and upon their arrival, state and/or federal resources will be integrated into the NIMS/ICS system.

IV. PLANNING ASSUMPTIONS

General Assumptions

1. The local healthcare organizations and agencies may implement such measures as necessary to protect the public's health as authorized.
2. Public demand for health information and health and medical services will increase during emergencies and disasters.
3. Public health emergencies may necessitate mass dispensation of medications or vaccinations to the public.
4. Public health emergencies may require implementation of public health measures to contain and control communicable diseases or spread of environmental hazards.
5. Essential goods and services, such as food, water, and medical supplies may be in short supply or unavailable.
6. The ability to mobilize and operate temporary facilities such as alternate care sites, and temporary morgues, will depend upon the ability to mobilize and transport staff and supplies from regional, state and/or Federal (i.e. Federal Medical Station) caches, private medical suppliers, and other sources; and may take multiple days to achieve and/or acquire.
7. Preparedness, response, and recovery efforts will incorporate and address the unique needs and circumstances of vulnerable populations that are economically disadvantaged, homeless, have limited language proficiency, have disabilities (physical, mental, sensory, or cognitive limitations), have special medical needs, experience cultural or geographic isolation, or are vulnerable due to age, as well as those of incarcerated persons and those with other access/functional needs.

Therefore, specific measures will be taken to ensure that these populations will have accessibility to information and health services.

Regional Assumptions

1. ESF 8 coordinating and cooperating agencies will commit resources and expertise as needed to address health and medical consequences of emergencies and disasters.

2. Infrastructure impacts such as damage to bridges or road closures may limit the ability to transport staff, patients, and supplies throughout the region.

3. The availability of emergency response resources and personnel could be limited in a regional disaster incident.

4. During a significant regional incident, routine emergency medical services may not be accessible through normal mechanisms.

5. Public health emergencies will likely impact neighboring municipalities/counties and healthcare organizations (both inside and outside the Kansas City Metropolitan Region) in each respective state (Kansas and Missouri) thereby limiting the availability of mutual aid.

6. A regional disaster incident may require the triage and treatment of large numbers of individuals (surge) which will have a direct impact on healthcare facilities in the Region.

7. Primacy will be given to preserving and maintaining life and safety. The capability of ESF 8 coordinating and cooperating agencies to fulfill non-health and medical resource requests, as outlined in other ESFs, will vary.

V. CONCEPT OF OPERATIONS

Public Health & Medical Services: Local Incident

A. Local Incident Management

1. Local officials and facilities/organizations retain primary responsibility for meeting public health and medical needs for their respective jurisdictions and service areas.

2. The vast majority of public health and medical activities and services are provided by the private healthcare sector. As such, local jurisdictions will work closely with their private-sector partners, as appropriate, to augment resources and capability needs.

3. Each jurisdiction is responsible for activating and operating its EOC according to local procedures. Local EOCs throughout the region are organized in different manners depending on the needs and capabilities of the jurisdictions, but all support an ICS and NIMS-based emergency structure.

B. Local Resource/Assistance Request Process

1. Local resource/assistance request processes will be conducted as defined in the local jurisdiction's or organization's respective plan(s).

2. When applicable, the Incident/Unified Command may request specialized or additional resources by contacting their own dispatch center (if the resources are available locally), or as defined in the jurisdiction's or organization's respective plan(s).

Public Health & Medical Services: Regional Incident

A. The information sharing and coordination mechanism for ESF 8 is the **Regional Healthcare Coordination System (RHCS),** which specifically addresses public health and medical needs within the Region. The nature of the incident/event and corresponding and evolving prevention, preparedness, mitigation, response and recovery needs will largely determine which participants will make up the RHCS at any given time during a public health and/or medical incident/event. See Figure 2.

B. The RHCS will also integrate with the broader Regional Coordination System (as described in Figure 3) during a regional emergency/disaster.

Figure 2. RHCS

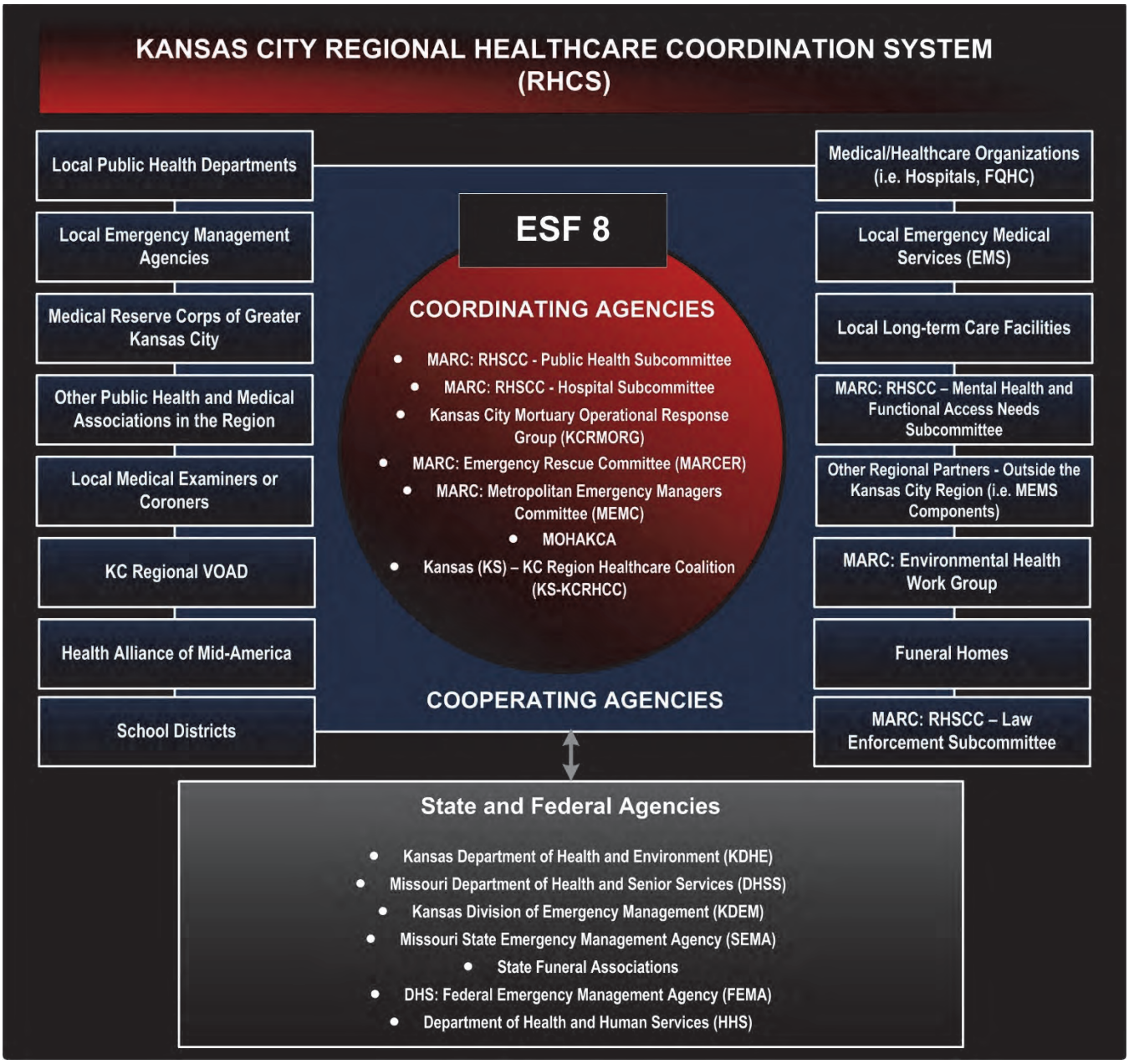
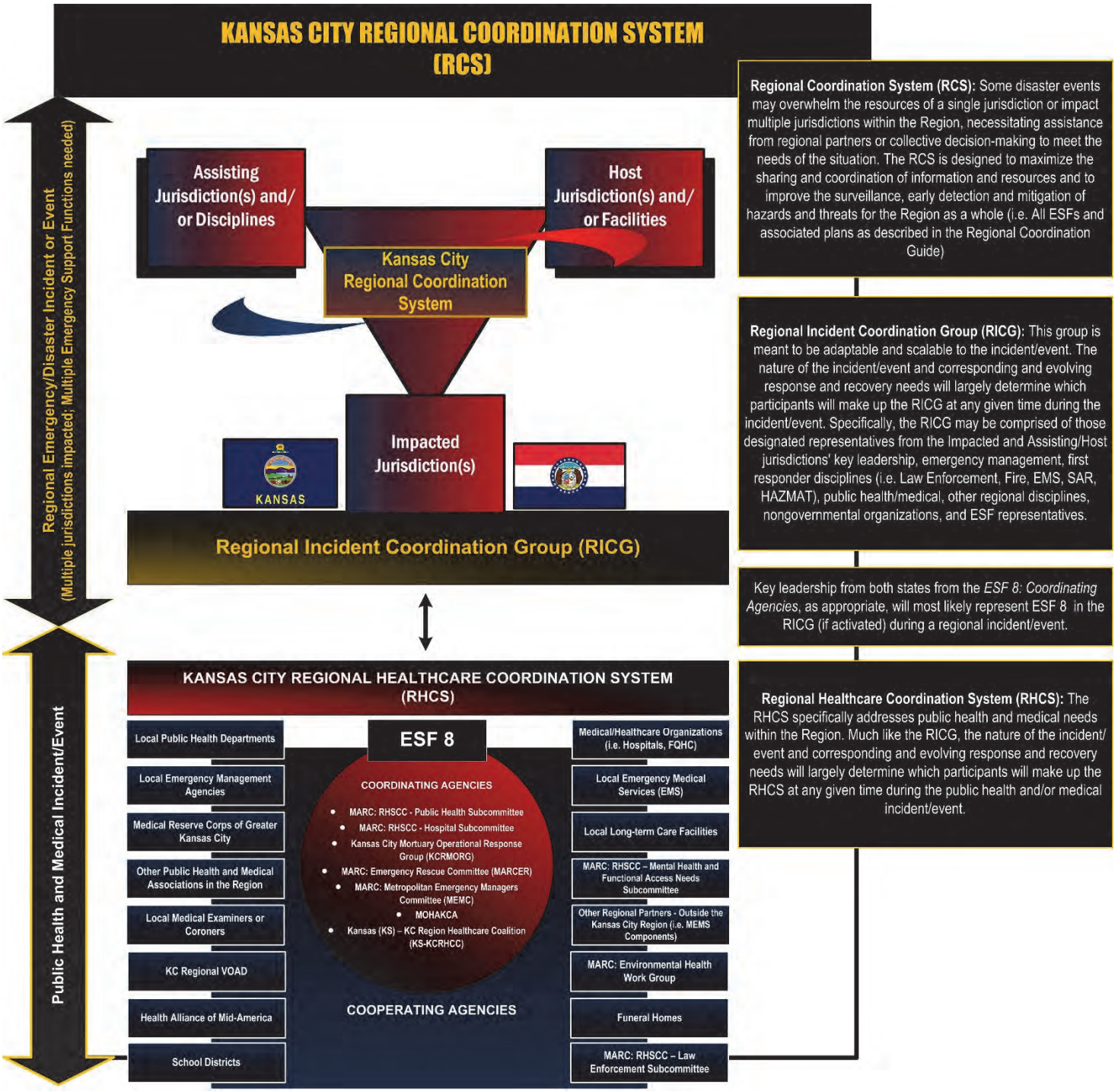


Figure 3. RCS and RHCS Integration



Activation and Regional Emergency Operations Coordination

Level 1 Incident

A. During a Level 1 incident, the Impacted Jurisdiction and/or healthcare organization/facility manages the incident locally or with normal mutual aid partners.
- Little to no regional support is expected at this time

B. The impacted jurisdiction(s) and/or healthcare organization(s)/facility(ies) shares information with the Region (ESF 8 Coordinating and Cooperating Agencies, as applicable) regarding the incident.

- See *CONOPS. Information Sharing*

C. ESF 8: Coordinating and Cooperating Agencies remain on standby.

D. Regional partners initiate appropriate public health and medical activities (i.e. Public Health Surveillance and Epidemiological Investigations), as appropriate, in order to proactively maintain situational awareness; and, if necessary, prepare, prevent, respond, and/or mitigate.

Level 2 Incident

A. During a Level 2 incident, the Impacted Jurisdiction and/or healthcare organization/facility continues to manage the incident locally.

- Moderate regional support may be needed at this time, as multiple jurisdictions and/or facilities may be affected during a Level 2 incident.

B. The impacted jurisdiction(s) and/or healthcare organization(s)/facility(ies) continue to share information with the Region (ESF 8 Coordinating and Cooperating Agencies, as applicable) regarding the incident.

C. In most cases, the impacted jurisdiction(s) and/or healthcare organization(s)/facility(ies) will determine the need to activate the Regional Healthcare Coordination System (RHCS), and will assume responsibility to convene appropriate ESF 8: Coordinating and Cooperating Agencies (see Figure 3). In the event the impacted jurisdiction(s) and/or healthcare organization(s)/facility(ies) is overwhelmed, the impacted jurisdiction and/or healthcare organization(s)/facility(ies) may delegate this responsibility.

- Because public health and medical challenges are no longer just local or regional, the RHCS may be initiated by **any** jurisdiction(s) and/or healthcare organization(s)/facility(ies) that has identified an issue (or potential issue) of regional/national significance by calling or e-mailing other coordinating and cooperating agencies in the Region and/or through the use of Web-based information management technology.

D. The impacted jurisdiction, or designee, will declare the RHCS level.

E. During a Level 2 incident, the impacted jurisdiction(s) and/or healthcare organization(s)/facility(ies) will initially arrange a conference call or meeting with other ESF 8: Coordinating and Cooperating Agencies, as applicable, to discuss needed regional coordination actions and develop a specific course of action.

F. If the situation escalates, a **Regional Healthcare Coordination Center** (RHCC) may be activated to provide a central point to coordinate health and medical operations for the Region.

G. Resource management (including any agreements) between Impacted, Assisting, and Host jurisdictions and/or healthcare organization(s)/facility(ies) are administered and managed at the local or organization/facility level, as applicable.

H. Requesting/receiving resources and support is made at the discretion of the Impacted Jurisdiction and/or healthcare organization(s)/facility(ies), which will allow them the ability to select what they need; and, in some cases, for what cost. The Assisting and/or Host Jurisdictions and/or healthcare organization(s)/facility(ies) only have to offer assistance if they have the resources and capabilities. At all times, Impacted Jurisdictions retain the choice of seeking resource support from either state or federal, or both, as may be appropriate for their circumstances.

I. The RHCS will coordinate cross-jurisdictional and/or organizational activities, as needed.

Level 3 Incident

A. During a Level 3 incident, the Impacted Jurisdiction and/or healthcare organization/facility continues to manage the incident locally.

  A. Significant regional support may be needed at this time, as multiple jurisdictions and/or facilities may be affected during a Level 3 incident.

B. The impacted jurisdiction(s) and/or healthcare organization(s)/facility(ies) continue to share information with the Region (ESF 8 Coordinating and Cooperating Agencies, as applicable) regarding the incident.

C. The impacted jurisdiction, or designee, will declare the RHCS level.

D. In most cases, the impacted jurisdiction(s) and/or healthcare organization(s)/facility(ies) will determine the need to activate the Regional Healthcare Coordination System (RHCS), and will assume responsibility to convene appropriate ESF 8: Coordinating and Cooperating Agencies. During a Level 3 incident/event, the need may be obvious and immediate actions should be taken to activate the RHCS. In the event the impacted jurisdiction(s) and/or healthcare organization(s)/facility(ies) is overwhelmed, the impacted jurisdiction and/or healthcare organization(s)/facility(ies) may delegate this responsibility.

E. During a Level 3 incident, the impacted jurisdiction(s) and/or healthcare organization(s)/facility(ies) may initially arrange a conference call with other ESF 8: Coordinating and Cooperating Agencies, as applicable, to discuss needed regional coordination actions and develop a specific course of action.

F. During a Level 3 incident, the Region should strongly consider convening the **Regional Healthcare Coordination Center** (RHCC), if appropriate. This will facilitate improved and timely regional coordination and decision-making, especially in an environment in which situations will evolve and change quickly, resources will be scarce, and life/safety concerns will be at their highest. It is also anticipated that a Level 3 incident will require more than just information sharing and resource coordination, such as in a Level 2 incident.

G. Resource management (including any agreements) between Impacted, Assisting, and Host jurisdictions and/or healthcare organization(s)/facility(ies) are administered and managed at the local or organization/facility level, as applicable. ESF 8, via the RHCS, may facilitate the prioritization of resource and support needs; however the authority and administration of the resources and support activities ultimately remains with the local jurisdiction.

H. Requesting/receiving resources and support is made at the discretion of the Impacted Jurisdiction and/or healthcare organization(s)/facility(ies), which will allow them the ability to select what they need; and, in some cases, for what cost. The Assisting and/or Host Jurisdictions and/or healthcare organization(s)/facility(ies) only have to offer assistance if they have the resources and capabilities. At all times, Impacted Jurisdictions retain the choice of seeking resource support from either state or federal, or both, as may be appropriate for their circumstances.

I. The RHCS will coordinate cross-jurisdictional and/or organizational activities, as needed.

Regional Healthcare Coordination Center (RHCC)

A. Activation of the RHCC may occur in several ways including, but not limited to:

- The IC(s) of the affected hospital(s) may request activation of the RHCC, when the need arises to coordinate simultaneously with several hospitals, or when facility personnel and equipment capabilities are exceeded.
- A local EOC may request activation of the RHCC to ensure regionally available healthcare resources are available to support local operations. Depending on the event, a healthcare agency representative already in their local EOC may request activation of the RHCC to assist their jurisdiction.
- Local Public Health Agencies (LPHA/LHDs) may request activation of the RHCC to assist in managing a healthcare related event to help ensure information is exchanged among agencies and between jurisdictions.
- EMS agencies may request activation of the RHCC to help with resources identification, or in a major mass casualty incident to ensure information is exchanged among agencies and between jurisdictions.
- District Healthcare Coordination Centers (DHCC), which are part of a broader plan to address public health and medical needs for the 13 counties in Missouri Region A, may request activation of the RHCC to facilitate coordination between the other DHCCs.

B. The RHCC will provide coordination and support activities, as needed.

1. Establish a mechanism for collecting and disseminating information regarding the availability of and need for healthcare resources, including, but not limited to, the following:

- Equipment
- Supplies
- Hospital bed capacities
- Personnel
- Special treatment capabilities
- Fatality management capabilities
- Transportation capabilities
- Alternate care site capabilities

2. Facilitate the sharing of resources and personnel among healthcare agencies and organizations in the Region.
3. Ensure a unified and coordinated incident management approach among the responding healthcare agencies and organizations in the Region.
4. Ensure a unified incident management approach with the other RCG: ESFs in order to ensure a coordinated regional response and recovery in the Region. Key members representing the RHCC should also participate and/or designate an individual or individuals to represent the public health and medical needs in the Regional Incident Coordination Group (RICG), as appropriate (see Figure 3).

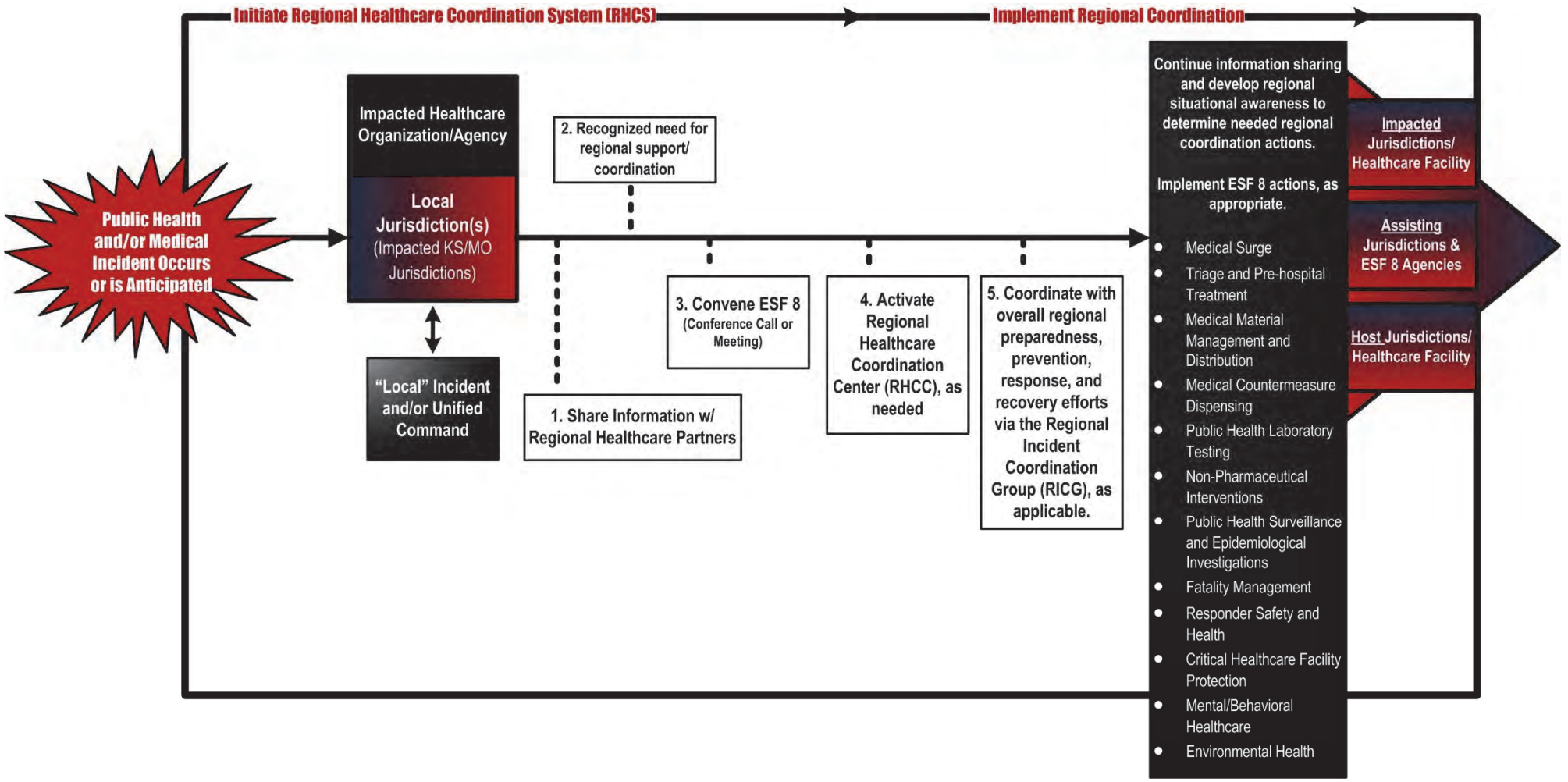
    - Key leadership from the *ESF 8: Coordinating Agencies*, as appropriate, will most likely represent the RHCC in the RICG (if activated) during a regional incident/event.

5. Provide a structure for healthcare agencies and organizations to communicate and coordinate among themselves, and with others involved in the event.
6. When dictated by the event, coordinate healthcare resources and personnel from outside the Region.
7. Ensure a mechanism is in place for centralized coordination with local, regional, state and federal emergency organizations.

Table 5. Regional Healthcare Coordination Center (RHCC)

Facility Name	Address	Max Capacity
Don Chisholm Center: Children's Mercy Hospital Campus	610 E. 22nd St. Kansas City, MO 64108	**8 individuals** Note: Additional training rooms are available
Emergency Operations Centers (EOC) in the Kansas City Region	**Will be determined, as needed.**	

Figure 4. RHCS Activation



Notification Process

General Notification Procedures

Notification for Biological and CBRNE Incidents

Biological Incident
NOTIFICATION AND ACTIVATION

- Each of the LPHA/LHDs in the metro-area maintains a system for emergency notification of an event requiring public health attention or action. The Missouri LPHAs rely on the capabilities of the Kansas City, Missouri (KCMO) Health Department's 24-hour duty officer number for emergency notification. The three (3) Kansas LHDs in the region each maintain their own 24-hour emergency duty officer numbers.
- Affected jurisdictions may recognize the immediate need for regional coordination and initiate activation of the Regional Healthcare Coordination System in order to facilitate regional situational awareness and communication amongst key Cooperating Agencies and stakeholders (i.e. law enforcement, EMS, hospitals, etc.).

    - Notification to LPHAs of a suspected biological incident may come through a direct call or page from any of many surveillance partners in the metro-area (i.e., physicians, hospitals, schools, pharmacies, etc.).
    - To encourage unusual event reporting, signs with the KCMO duty officer number are posted in Missouri hospital emergency departments, laboratories, infection control practitioner offices, and other locations. Additionally, the LHDs in the State of Kansas provide the hospitals, clinicians, labs and other appropriate partners in their jurisdictions with emergency contact numbers for use in the event of a suspected biological incident.
    - Notification of a biological event may come through one of several public health and medical notification and communications systems in place throughout the metropolitan area, including the two Health Alert Networks (HANs) serving the area. The Kansas City, Missouri LPHA (by contract with DHSS) serves as the regional HAN hub for the Missouri side of the metropolitan area and KDHE's HAN serves the Kansas side.
    - The HAN will be one of the primary ways in which public health officials, physicians, hospitals, laboratories, emergency medical services agencies, etc., may be notified of a biological incident that affects or could affect the Kansas City metro-area. The HAN will be used for notification and to disseminate various types of information, such as guidelines, recommendations, and status reports to the medical community, first responders, the media and others.
    - In addition, the Public Health Information Exchange (PHIX) is a public health information sharing and communications systems operated by the State of Kansas used to provide information to Kansas LHDs. In Missouri, LPHAs receive disease surveillance information from MOHSIS.
    - Notification of a biological incident may come from hospitals and/or EMS agencies through the EMSystem, the region's primary method of communicating hospital status. The EMSystem is a web-based program providing real-time information on hospital emergency department status, patient capacity, the availability of staffed beds and specialized treatment capabilities.
    - Another EMS reporting mechanism called "First Watch" may also be used to notify the LPHA/LHDs.
    - Procedures and contact information for LPHA/LHDs notification to Emergency Management Agencies (EMAs), hospitals and others are included in local plans. **After making these notifications, the affected LPHA/LHDs may recognize the need for regional coordination and initiate activation of the Regional Healthcare Coordination System.**

CBRNE Incident
NOTIFICATION AND ACTIVATION

- When a CBRNE event occurs, the impacted jurisdiction may activate the specialized resources and personnel located in their jurisdiction, and/or they may request additional or specialized mutual aid resources in other jurisdictions to respond to the event.
- Affected jurisdictions may recognize the immediate need for regional coordination and initiate activation of the Regional Healthcare Coordination System in order to facilitate regional situational awareness and communication amongst key Cooperating Agencies and stakeholders (i.e. law enforcement, EMS, hospitals, etc.).
- The IC may request specialized or additional resources by contacting their own dispatch center (if the resources are available locally) or by contacting the Region A Statewide Mutual Aid Coordinator at the Lee's Summit Fire Department to request resources from other jurisdictions.
- Upon notification, the receiving Region A dispatcher will immediately notify both the Kansas City, Kansas and Kansas City, Missouri Fire Departments (unless they are the original requesting agency), who are the primary contacts for notifying the agencies with specialized resources located nearest to the incident, and requesting that they be deployed to the scene.
- The type and location of the hazard will determine the type and location of the resources deployed. Depending on the magnitude of the event, specially trained personnel and resources in jurisdictions throughout the region may be notified, and if necessary, sent to the scene(s).
- When needed, the Region A Mutual Aid Coordinator may also contact the appropriate local EMS agencies and request their dispatch to the scene, as noted in the MARCER MCI Plan (see Attachment D).
- Notification and alert to other agencies and organizations needed in support of a mass casualty incident will be accomplished through established local dispatching capabilities and local EOCs. The local Emergency Management Agencies (EMAs) in each jurisdiction will notify the appropriate Department Directors and other necessary government officials and local agencies of the incident. When necessary, EMAs will activate their local EOCs to coordinate emergency activities.
- If the incident originates as a public health emergency (i.e. a biological event) the local Public Health Agency (LPHA) will notify the local Emergency Management Agency (EMA) and other first responder agencies by telephone, pager and through the Health Alert Network (HAN).
- Communications regarding hospital status during mass casualty events will occur using the EMSystem, a web-based program providing real-time information on hospital emergency department status, patient capacity, and the availability of staffed beds and specialized treatment capabilities.
- The hospitals will maintain communications with their respective local EOCs and the scene. For more information on the EMSystem, HEAR and EMS-Hospital communications, see Attachment I – Forward Movement of Patients and Attachment J – Hospitals and Healthcare Systems, as well as Attachment D - MARCER Mass Casualty Incident Plan and Attachment K - EMSystems Policies and Protocols Manual.
- Emergency communications may be accomplished in accordance with the Tactical Interoperable Communications (TIC) Plan.

Information Sharing & Communications

A. The following information sharing systems and communication mechanisms for ESF 8 are available to the Region. See Attachment P: Technologies and Systems Overview.

- Biosense
- Dispense Assist
- EMResource
- EpiTrax
- First Watch
- Health Alert Networks (HAN)
- Hospital Emergency and Administrative Radio System (HEAR)
- MISSOURI ESSENCE
- Missouri Health Strategic Architecture and Information Cooperative (MOHSAIC)
- Missouri Telehealth Network (MORENET)
- The Kansas Countermeasure Response Administration (KS-CRA)
- WEBEOC
- X-Sentinel

B. **Communications (TIC) Plan**. The TIC Plan is maintained by the Regional Interoperability Committee, a policy group representing public safety agencies throughout the region.

- The TIC Plan documents the interoperable communications resources available in the metro-area, as well as the agencies that control each resource, and operational procedures for the activation and deactivation of each resource. See RCG: ESF 2 - Communications.

C. **Mobile Communications**. Several jurisdictions in the region have new, mobile communications vehicles available for deployment to support on-site emergency operations through a host of interoperable communications networks and tools. The interoperability equipment contained in the mobile communications vehicles varies slightly but includes tools such as:

- Radios and interoperability equipment
- Computers with access to on-board and remote databases and dispatch information
- GIS/Mapping capabilities
- Telephone systems with internal and external extensions served by landline and cellular service
- Cellular/Wi-Fi/Radio systems with an onboard antenna system for field connectivity
- Low light mounted cameras for video capture

Emergency Public Information

A. Public information activities during a public health and medical incident/event will be managed using the organization and protocols described in RCG: ESF 15 - Emergency Public Information.

B. The public information annexes contained in local EOPs detail the dissemination of timely emergency information, as well as media, public and community affairs. Most local EOPs in the region also address the establishment of a Joint Information Center (JIC) and using a Joint Information System (JIS) to coordinate the release of timely, accurate and consistent information.

C. The release of consistent emergency public information among all the jurisdictions involved in an incident is critical. With this in mind, the Regional Association of Public Information Officers (RAPIO) with assistance from the RHSCC Public Health Subcommittee Risk Communications Task Force has developed guidelines for establishing a regional public information coordination system and a public information mutual aid system to support local operations. These guidelines are included as part of the RCG. Attachment Q: Protocol for Regional News Releases provides specific guidance on issuing regional news releases.

Medical Surge Coordination and Operations

Description:
Medical surge is the ability to provide adequate medical evaluation and care during events that exceed the limits of the normal medical infrastructure of an affected community. It encompasses the ability of the healthcare system to survive a hazard impact and maintain or rapidly recover operations that were compromised.

This operation consists of the ability to perform and/or coordinate the following functions:

- Assess the nature and scope of the incident
- Support/coordinate activation of medical surge
- Support/coordinate jurisdictional medical surge operations
- Support/coordinate demobilization of medical surge operations

A. Coordinating and Cooperating Agencies

- **Coordinating**
  MARCER
  MARC: RHSCC - Hospital Subcommittee
  Kansas (KS) - Kansas City Region Healthcare Coalition (KS-KCRHCC)

- **Cooperating**
  Medical/Healthcare Organizations (i.e. Hospitals, FQHCs))
  Local Emergency Medical Services (EMS)

B. Regional Plans/Strategies/Systems

Attachment C: Regional Healthcare Coordination Guide
Attachment D: MARCER MCI Plan
Attachment E: Community Plan for Ambulance Diversion for the Greater Kansas City Metropolitan Area
Attachment F: MARCER Regional High Demand Plan
Attachment I: Kansas City Regional Patient Movement Plan
Attachment K: EMSystem Protocols and Policies Manual

Mass Patient Care and Casualties

- The number of casualties resulting from a public health and medical incident will determine the ability of the local hospital and healthcare community to manage the incident with existing resources, or the need to establish alternate medical care facilities to effectively handle large numbers of casualties.

- The ability of metro-area hospitals to expand their patient care capabilities is covered in each hospital's emergency plan. Hospital emergency plans identify space within their own facilities or campuses that may be used to expand the number of available acute care beds by modifying patient rooms and utilizing all areas capable of accommodating additional beds.
- Additional hospital medical surge capacity (beds) may also be augmented by canceling elective admissions, expediting the discharge of current patients and transferring those appropriate to long term acute care facilities.
- Depending on the magnitude of the event, such expansion may not be adequate to manage the number of patients in need of definitive care. In this event, hospital emergency plans identify facilities adjacent or convenient to their institutions that may be equipped and staffed to serve as temporary Alternate Care Sites (ACS).
- Based on the needs of the event, hospitals will coordinate with LPHA/LHDs and local EOCs to establish ACSs. It is anticipated that the number of ACSs established and their locations will be based on the population affected, as well as the ability of hospitals and local jurisdictions to staff and manage such facilities.
- Most local EOPs include lists of facilities for use as temporary emergency shelters. Depending on the magnitude and nature of the incident/event, some of these facilities (if given an expanded scope and adequate staffing) may be suitable for use as ACSs.
- Once established, ACSs are normally under the administrative direction of a hospital. However, if the hospital is overwhelmed and unable to provide oversight, early consideration should be given to request support from the State of Kansas or Missouri for resources such as the National Guard, State or Federal Disaster Medical Assistance Team (DMAT) and/or Federal Medical Station (FMS) to create additional capacity. The National Disaster Medical System (NDMS) may have additional resources such as the National Ambulance Contract to support movement of patients.
- Additional personnel support for ACSs may be provided by contract staff, the Medical Reserve Corps of Greater Kansas City and local volunteer agencies. Based on the needs of the situation, standards of care may be modified to allow additional personnel to provide care in ACSs.
- State and federal assets (materiel, patient transportation, additional health care workers and medical facilities) needed to provide support to temporary ACSs will be requested through local EOCs.
- For additional information on medical surge capacity and ACSs, see Attachment I – Forward Movement of Patients and Attachment J – Hospitals and Healthcare Systems.

Medical Personnel, Supplies and Equipment

- The management of medical personnel will be conducted in accordance with the ICS established at the scene (see "Incident Management") and the Hospital Emergency Incident Command System (HEICS) established at each definitive care facility (see Attachment J – Hospitals and Healthcare Systems).
- The augmentation of medical personnel will be requested through hospitals and EMS mutual aid. Additional augmentation of medical personnel will be requested through local EOCs. The trained personnel of Medical Reserve Corps (MRC) may be used to augment local public health and medical staff. MRC personnel may be deployed to the scene, a medication dispensing site, a treatment center or other location where their services are needed.
- If necessary, local EOCs will request through the state the resources of the NDMS to augment local medical personnel. NDMS resources include Disaster Medical Assistance Teams (DMATs) to assist with patient care and Disaster Mortuary Operations Teams (DMORTs) to assist with mass fatalities management, including teams with special CBRNE training.

- Standard medical supplies and equipment for hospitals and EMS agencies will be provided through mutual aid agreements with surrounding agencies. If necessary, additional supplies and equipment will be requested through local EOCs and coordinated with other jurisdictions in the region.
- Logistical support for personnel, equipment and supplies are described in local EOPs and in RCG: ESF 7 - Logistics. In a major event affecting several jurisdictions in the region, a resource tracking system may be implemented to support regional mutual aid requirements for logistical support beyond local capabilities.

C. Available Resources to the Region

See Regional Resource Annex: ESF 8

D. Regional Limitations and/or Considerations

Currently, there are a limited number of ambulances in the Region.

Triage and Pre-Hospital Treatment

Description:
Impacted jurisdictions may need to coordinate in emergency pre-hospital care for mass casualty events. During an emergency, pre-hospital care may involve more than one jurisdiction, therefore ICS will be used to help standardize organizational structure and common terminology and to ensure a useful and flexible management system is practical for incidents involving multi-jurisdictional and multi-agency response, especially those in the field.

A. Coordinating and Cooperating Agencies

- **Coordinating**
  MARCER
  MARC: RHSCC - Hospital Subcommittee
  Kansas (KS) - Kansas City Region Healthcare Coalition (KS-KCRHCC)

- **Cooperating**
  Local Emergency Medical Services (EMS)
  Medical/Healthcare Organizations (i.e. Hospitals, FQHCs)

B. Regional Plans/Strategies/Systems
Attachment D: MARCER MCI Plan
Attachment E: Community Plan for Ambulance Diversion for the Greater Kansas City Metropolitan Area
Attachment F: MARCER Regional High Demand Plan
Attachment I: Kansas City Regional Patient Movement Plan
Attachment K: EMSystem Protocols and Policies Manual
TCD Plan

Patient Triage, Tracking and Recordkeeping

- Responding EMS support agencies will assume responsibility for patient triage, treatment and tracking under the guidelines set forth in the MARCER Regional Mass Casualty Incident (MCI) Plan.
- EMS personnel will coordinate and track the delivery of patients to individual hospitals throughout the metropolitan area utilizing the EMSystem and local medical channels.
- Comprehensive recordkeeping of the event will be accomplished by local EOCs in the metropolitan area using local procedures and the capabilities of WebEOC, an electronic crisis information management system. This information will be shared with appropriate local, regional, state and federal agencies.

C. Available Resources to the Region

See Regional Resource Annex: ESF 8

D. Regional Limitations and/or Considerations

- Currently, there are a limited number of ambulances in the Region.
- No electronic patient tracking system exists for the Region at this time.

Medical Materiel Management and Distribution

Description:
Medical materiel management and distribution is the ability to acquire, maintain (e.g., cold chain storage or other storage protocol), transport, distribute, and track medical materiel (e.g., pharmaceuticals, gloves, masks, and ventilators) during an incident and to recover and account for unused medical materiel, as necessary, after an incident.

This operation consists of the ability to perform and/or coordinate the following functions:

- Coordinate medical materiel management and distribution
- Coordinate acquisition of medical materiel
- Maintain updated inventory management and reporting system
- Coordinate and maintain security
- Distribute medical materiel
- Recover medical materiel and demobilize distribution operations

A. Coordinating and Cooperating Agencies

- **Coordinating**
  MARC: RHSCC - Public Health Subcommittee

- **Cooperating**
  Local Public Health Agencies
  Medical/Healthcare Organizations (i.e. Hospitals, FQHCs)
  Local Emergency Medical Services (EMS)
  MARC: RHSCC – Law Enforcement Subcommittee
  KC Regional VOAD

- **State and Federal Agencies**
  Kansas Department of Health and Environment (KDHE)
  Missouri Department of Health and Senior Services (DHSS)
  Department of Health and Human Services (HHS)
  Center for Disease Control and Prevention (CDC)

B. Regional Plans/Strategies/Systems

- Attachment L: Hospital and Public Health Coordination to Provide Medical Countermeasures

Pharmaceuticals and the SNS:

Pharmaceuticals

- Depending on the specifics of the event, the use of local and regional pharmaceutical supplies will most likely be needed prior to arrival of SNS resources. The availability of local pharmaceutical assets will vary depending on the prophylactic medication required.
- LPHA/LHDs and EOCs will work with retail pharmacies, as well as pharmaceutical wholesalers to help replenish initial pharmaceutical stocks at hospitals and medical facilities for the first 24 hours after detecting a biological event.
- Since pharmaceutical supplies in the region are limited, the use of local pharmaceuticals will most likely be available for some, but not all persons in need of prophylaxis. Local pharmaceutical supplies will be used to provide prophylaxis to essential personnel and their families, as well as to the contacts of ill persons based on epidemiological investigation by LPHA/LHDs.
- Hospitals in the metro-area may have pharmaceutical caches on hand to provide priority prophylaxis for their personnel. Hospitals will work closely with LPHA/LHDs to ensure the appropriate prophylaxis medications are available to their personnel, if available.

Activation of the SNS

- The SNS is comprised of pharmaceuticals, vaccines, ventilators, medical supplies, and medical equipment to augment state and local resources for responding to public health and medical emergencies. SNS packages are stored in strategic locations throughout the United States to help ensure rapid delivery.
- LPHA/LHDs will determine when sufficient need exists to make a request for the SNS. Requests for the SNS will initiate from local EOCs in the affected jurisdictions and be coordinated per local SNS Plans. Each local Public Health Officer will follow the chain of command to recommend requests for SNS resources through the Governor's office.

Deployment and Delivery of the SNS

- It is anticipated that SNS Push Package assets will arrive at point of transfer to the State within twelve (12) hours of the federal decision to deploy them. However, since SNS materiel may require substantial time to offload, stage, apportion and further transport, it is anticipated that SNS assets will be available for distribution within 48 – 72 hours of federal deployment.
- In most cases, the SNS will arrive by air or ground in two phases as follows:
  - Phase 1: Push Package – a complete package of medical materiel including nearly everything a state will need to respond to a broad range of threats.

  - Phase 2: SNS Inventory – including supplies tailored to provide pharmaceuticals, vaccines, medical supplies, and/or medical products specific to the suspected or confirmed agent or combination of agents.
- Additionally, CDC maintains a SNS Services Advance Group (SSAG), which is a tailored pool of specialized federal responders available to assist during a public health emergency.
- DHSS/SEMA in Missouri and KDHE/KEM in Kansas will communicate to local jurisdictions regarding SNS plans, expectations and requirements. When the SNS PUSH Package arrives, it will be the responsibility of DHSS and/or KDHE to provide for receipt, staging, storage and security.
- DHSS and KDHE will coordinate receipt, breakdown and distribution of the SNS throughout their respective States.
- Missouri LPHAs will identify properly authorized individuals and security to pick up SNS assets from the Reception, Staging and Storage site. Missouri LPHAs and EOCs will coordinate with local law enforcement agencies to transport SNS assets to secure local distribution centers.
- In Kansas, KDHE has agreed to ensure delivery of SNS assets from the state managed Reception, Staging and Storage site to secure local distribution sites where authorized officials will take delivery of SNS materiels.
- Decisions regarding the movement and security of SNS resources will be made in local EOCs using ICS and NIMS principles. The movement of SNS materiels will be accomplished using the transportation, equipment and law enforcement resources identified in local EOPs. When necessary, the EOC Logistics Section will work to obtain vehicles that will transport personnel who are authorized to move pharmaceuticals requiring special handling.

Regional Coordination Activities

- Coordination and identification of target populations
- Coordination of security needs
- Medical materiel identification, acquisition, and distribution

C. Available Resources to the Region

See Regional Resource Annex: ESF 8

D. Regional Limitations and/or Considerations

- A regional plan to coordinate medical materiel management and distribution is needed.

Medical Countermeasure Dispensing

Description:

Medical countermeasure dispensing is the ability to provide medical countermeasures (including vaccines, antiviral drugs, antibiotics, antitoxin, etc.) in support of treatment or prophylaxis (oral or vaccination) to the identified population in accordance with public health guidelines and/or recommendations.

This operation consists of the ability to perform and/or coordinate the following functions:

- Coordinate medical countermeasure dispensing strategies
- Receive medical countermeasures
- Coordinate activation of dispensing modalities
- Coordinate dispensing of medical countermeasures to identified populations
- Share reports of adverse events

A. Coordinating and Cooperating Agencies

- **Coordinating**
  MARC: RHSCC - Public Health Subcommittee

- **Cooperating**
  Local Public Health Agencies
  Medical/Healthcare Organizations (i.e. Hospitals, FQHCs)
  Local Emergency Medical Services (EMS)
  MARC: RHSCC – Law Enforcement Subcommittee
  KC Regional VOAD

B. Regional Plans/Strategies

- Attachment L: Hospital and Public Health Coordination to Provide Medical Countermeasures

Mass Prophylaxis

- LPHA/LHDs, in consultation with state and federal health officials, will provide guidance on appropriate treatment (e.g., types and dosages of vaccines or antibiotics) for exposed persons. The local Public Health Officer, or designee, will maintain contact with the state health department (DHSS and/or KDHE) for state-specific guidelines. LPHA/LHDs will work to share information regarding state specific instructions and formulate common messages for the public.
- Mass dispensing plans, or related plan(s), maintained by each jurisdiction detail the management of mass prophylaxis dispensing operations at the local level. Although these local plans and procedures are similar they are not identical. Coordination between jurisdictions will be required to help ensure that clear and consistent information is provided to the public. Activation of the Regional Healthcare Coordination System as described earlier will assist in accomplishing such coordination.

- Key Assumptions:

  - Only asymptomatic persons will receive prophylaxis at any dispensing site.
  - Symptomatic persons may be sent home, diverted to a health care facility or to an Alternate Care Site, if available.
  - Any person exposed to a potentially infectious disease while in the metro-area will receive prophylaxis from the jurisdiction in which they reside.
  - Visitors in the metropolitan area not staying in a private residence (e.g., individuals in hotels) will be directed to report to the nearest public prophylaxis dispensing site.

Dispensing Operations

- As described in local mass dispensing plans, or related plan(s), LPHA/LHDs in the metropolitan area may establish and manage Points of Dispensing (PODs) to provide prophylactic medication to the public.

  LPHA/LHDs may establish PODs for the general public (Open Sites) and for specific pre-identified groups of individuals such as large employers, schools and special facilities (i.e.,

Closed Sites). Site locations and specific instructions for pre-identified groups will be communicated to the appropriate populations by LPHA/LHDs and coordinated with other LPHA/LHDs in the metro-area via the RHCS.

- The location of PODs for the general public (Open Sites), as well as dates, times and hours of operation will be coordinated by the LPHA/LHDs in the region via the RHCS. This information will be communicated via the local media and coordinated through local EOCs and Joint Information Centers (JICs).

Priority Prophylaxis

- Priority Prophylaxis will be provided to first responders such as LPHA/LHDs, hospitals, law enforcement agencies, fire departments, EMS agencies and volunteers working in the mass prophylactic efforts. Protocols for priority prophylaxis dispensing are included in local plans including pre-identified personnel and their contact information.
- After providing prophylaxis to these essential personnel, any additional initial available supplies of prophylactic medications will be provided to ill persons and their contacts based on recommendations from public health staff as established through epidemiological investigation.

PODs Site Selection

- Each local jurisdiction in the metro-area has pre-selected locations to use as prophylaxis dispensing sites for their populations. Based on their strategic and familiar locations, many jurisdictions have identified schools as their primary PODs. Schools normally meet other criteria for site selection as well, such as adequate parking, access to transportation corridors, infrastructure, security considerations and temperature maintenance.
- Specific POD sites are identified in local plans and maps locating these sites are kept on file with the LPHA/LHDs and/or EMAs. The number of dispensing sites activated for the incident will be determined by the jurisdictions involved and will depend on the projected number of individuals needing prophylaxis and their distribution throughout the area, as well as resource and personnel capabilities.
- Decisions regarding how many sites to open, their locations and hours of operation will be coordinated between the affected jurisdictions through the RHCS. The timeline established for prophylaxis dispensing will be determined by LPHA/LHDs depending on the disease agent involved.

PODs Operations

- Once LPHA/LHDs determine the final numbers and locations of PODs, local response teams will be dispatched to their assigned sites. Site teams members may include:

  - Registered Nurses
  - Pharmacists
  - Physicians
  - Volunteers
  - Mental Health Personnel
  - Security Personnel

- The number of each type of personnel required will depend on the number of individuals expected to report for prophylaxis, as well as the distribution and number of sites established throughout the metropolitan area. An ICS based organizational structure, projected staffing patterns and job descriptions for each dispensing site position are included in local mass dispensing plans, or related plan(s).
- The number and location of sites will determine the need for resource and personnel sharing between affected jurisdictions. Decisions regarding the best use of available resources for prophylaxis dispensing operations will be made by LPHA/LHDs and coordinated through the RHCS.
- The sharing of resources and personnel will be facilitated by all of the jurisdictions in the metro-area using a similar ICS structure, staffing pattern and job descriptions for POD activities. Although the jurisdictions in the metro-area currently have different staffing patterns for POD activities, they are all ICS based allowing for flexibility and the sharing of personnel resources.

Emergency Public Information

- Local EOCs and Joint Information Centers (JICs) will disseminate information to the public regarding prophylaxis dispensing sites. It is particularly important that public information activities be coordinated among the involved jurisdictions (via the RHCS) to ensure the consistency and clarity of messages. Public information should be coordinated as described in RCG: ESF 15 – Emergency Public Information.

  Regionally coordinated public information regarding prophylaxis dispensing sites should include:

  - Site locations and populations to report
  - Hours of operation
  - What to bring and what to expect
  - Public transportation routes and available special transportation, if appropriate
  - The importance of only asymptomatic individuals reporting for prophylaxis
  - Actions for persons not exposed
  - Listings of additional public information resources (i.e., web sites, toll free numbers, special broadcasts, etc).
  - "Head of Household Only" policy and messaging

- There are many additional items that may be considered for public release depending on the agent involved and populations affected. Public information decisions will be made by LPHA/LHDs personnel in coordination with local EOCs and JICs as described in the Public Information Annexes of local EOPs.

Functional and Access Needs Populations

- A coordinated effort will be made by the LPHA/LHDs in the region to reach identified functional and access needs populations with information regarding the availability of prophylactic medications. Specifically, LPHA/LHDs will work through volunteer and community based organizations with existing ties to these groups in the metro-area. Such outreach efforts will help to ensure that timely and appropriate information is disseminated to these populations regarding PODs.
- PODs may be located near existing public transportation routes to help ensure adequate public transportation is available to those without personal vehicles. Special bus routes may

be initiated to meet such needs. When necessary, LPHA/LHDs will work through local EOCs to assist those without access to public transportation with transportation to the POD.

- Adults may be instructed to pick up prophylactic medications for children, family members, homebound relatives and close contacts. Public information materials will be disseminated describing the ability to collect medications for others, as well as the type of information that will be required when picking up medications (i.e., demographics, health history, the weight of children, etc.).
- Depending on the specifics of the event, the LPHA/LHDs in the region will enact appropriate pediatric protocols for children in schools and licensed childcare facilities.
- Every effort will be made to provide adequate public information regarding the availability of prophylactic medications to non-English speaking residents. Assistance with the translation and dissemination of information regarding PODs will be sought from local agencies with the ability to conduct outreach in languages other than English.
- Distribution of prophylactic medication to the homeless will be coordinated through local mental health and volunteer agencies in coordination with the LPHA/LHDs and EOCs.
- Local jurisdictions are responsible for working with law enforcement agencies and correctional facilities to address the provision of prophylactic medications for incarcerated individuals. In most cases, LPHA/LHDs have made arrangements to treat correctional facilities as closed sites.

Vaccination Considerations

- Vaccinations may be required in the presence of a disease that may be mitigated by the administration of a vaccine to prevent further spread of the disease (e.g., Smallpox, Influenza or Meningitis).
- Vaccinations will occur at PODs and be provided to functional and access needs populations and closed sites in basically the same manner as pill dispensing.
- All vaccinations will be performed in accordance with LPHA/LHDs adult and pediatric immunization protocols. Specific vaccination guidelines are included in local Mass Dispensing Plans, or related plan(s), including procedures for vaccine handling and storage.

C. Available Resources to the Region

See Regional Resource Annex: ESF 8

D. Regional Limitations and/or Considerations

A regional plan to coordinate medical countermeasure dispensing is needed.

Public Health Laboratory Testing

Description:

Public health laboratory testing is the ability to conduct rapid and conventional detection, characterization, confirmatory testing, data reporting, investigative support, and laboratory networking to address actual or potential exposure to all-hazards. Hazards include chemical, radiological, and biological agents in multiple matrices that may include clinical samples, food, and environmental samples (e.g., water, air, and soil).

The role of LPHA/LHDs in Laboratory testing is the management of specimen collection - which varies based on the type of specimen and the state requirements. Forensic specimens are managed by Law Enforcement. The LPHA/LHDs functions as a liaison between the state and the practitioner for transport

of human specimens. The LPHA/LHDs communicates information concerning maintaining chain of custody with practitioners and the state.

This operation consists of the ability to perform and/or coordinate the following functions:

- Manage laboratory activities
- Perform sample management
- Conduct testing and analysis for routine and surge capacity
- Support public health investigations
- Share report results

A. Coordinating and Cooperating Agencies

- **Coordinating**
  MARC: RHSCC - Public Health Subcommittee
  MARC: RHSCC - Hospital Subcommittee

- **Cooperating**
  Local Public Health Agencies
  Medical/Healthcare Organizations (i.e. Hospitals, FQHCs)
  MARC: RHSCC – Law Enforcement Subcommittee

B. Regional Plans/Strategies

LPHA/LHDs maintain epidemiology sections responsible for investigating disease reports. Local epidemiology departments will work closely with the states (i.e., KDHE and DHSS) to augment investigations with guidance and personnel when needed.

- Laboratory diagnosis will be a critical step in the timely control of a biological public health emergency. The states laboratories (KDHE and DHSS) are responsible for providing diagnostic expertise and specimen handling to support the LPHA/LHDs in disease investigations.
- LPHA/LHDs maintain contact information for state laboratories, which serve as the entry point for biological specimens to be tested or referred on to other laboratories. Specimens may be referred to the state laboratories from hospitals and/or health care providers. LPHA/LHDs will coordinate such referrals as necessary.
- Biological specimen packaging and transport must be coordinated between LPHA/LHDs and the state labs, as well as with local EOCs and law enforcement officials. When necessary, law enforcement will work with LPHA/LHDs to ensure a chain of custody of specimens from the time of collection.
- Chemical Event Shipping Supply Locations (CESSL) Program: In the State of Kansas, the CESSL program allows for prepositioning of category B shipping containers and packaging materials which will enable the Health Professionals closest to a chemical event to collect specimens from persons within the exposure area. KDHE and KHEL have created cache sites based on distance distribution and population density at many hospitals throughout Kansas. KDHE maintains a list of these sites. More information is available from local health departments or KDHE.

Sampling & Testing: Biological Agents

- When an identified biological agent poses no environmental threat, LPHA/LHDs may declare that no hazard exists. But in other cases, the biological agent or its' potential environmental hazards may be unknown and require sampling and testing. In this case, samples will be collected, packaged, and sent to state, federal or private laboratories for testing.
- LPHA/LHDs and first responder agencies will work with the local FBI office regarding the transportation of biological samples to state laboratories for testing. After notification to the laboratory, transportation of the samples will be handled by an appropriate law enforcement agency (FBI or local law enforcement) as agreed upon by the local FBI office.
- Chain-of-custody paperwork will be required for biological samples unless otherwise determined by the FBI and local law enforcement. Responsibility for samples will be transferred to laboratory staff through chain-of-custody paperwork. Both state laboratories are secure facilities and security may be enhanced further if deemed appropriate by the FBI.
- The state laboratory will test the samples and if appropriate, confer with and/or refer the sample material to the CDC. The state laboratory will communicate its findings and actions to LPHA/LHDs.

Non-Pharmaceutical Interventions

Description:
Non-pharmaceutical interventions are the ability to recommend to the applicable lead agency (if not public health) and implement, if applicable, strategies for disease, injury, and exposure control. Strategies include the following:

- Isolation and quarantine
- Restrictions on movement and travel advisory/warnings
- Social distancing
- External decontamination
- Hygiene
- Precautionary protective behaviors

This operation consists of the ability to perform and/or coordinate the following functions:

- Engage partners and identify factors that impact non-pharmaceutical interventions
- Determine and coordinate non-pharmaceutical interventions
- Coordinate and implement non-pharmaceutical interventions
- Monitor non-pharmaceutical interventions

A. Coordinating and Cooperating Agencies

- **Coordinating**
  MARC: RHSCC - Public Health Subcommittee
  MARC: Metropolitan Emergency Managers Committee (MEMC)

- **Cooperating**
  Local Public Health Agencies
  Medical/Healthcare Organizations (i.e. Hospitals, FQHCs)

Local Emergency Medical Services (EMS)
Local Long-term Care Facilities
MARC: RHSCC - Mental Health and Functional and Access Needs Subcommittee
MARC: RHSCC – Law Enforcement Subcommittee

B. Regional Plans/Strategies

Evacuation

All evacuation decisions will be made by the IC/UC and/or the EOC as described in local EOPs and their supporting procedures and guidelines.

Disease Containment

All disease containment decisions (i.e., isolation, quarantine, etc.) will be made by the IC/UC and/or the EOC as described in local EOPs and their supporting procedures and guidelines. Specific disease containment procedures are detailed in local plans.

Isolation and Quarantine

General

- According to Kansas and Missouri statutes, local Public Health Officers in each jurisdiction have legal responsibility for ordering the isolation of ill individuals and the quarantine of those exposed but not yet ill. Local Public Health Officers in the metro-area will determine the need for isolation and/or quarantine procedures based on the disease agent, as well as state and federal guidelines and recommendations.
- To assist in maintaining consistent actions throughout the metro-area, local Public Health Officers will work to the extent possible within the RHCS. Public Health Officers in the region should coordinate to determine the need for isolation and/or quarantine measures, and the appropriate actions for enforcement of such measures.
- LPHA/LHDs will provide guidance to the public on isolation and/or quarantine measures. It is important that LPHA/LHDs coordinate to develop regionally consistent public messages regarding isolation and/or quarantine. The LPHA/LHDs will also work closely with the State Departments of Health (DHSS and KDHE) and the CDC to determine appropriate crisis communications strategies.
- Local Public Health Officers may consider closing large public venues and other measures to mitigate the spread of disease. Such actions will be implemented based on the situation and should be closely coordinated among the jurisdictions in the region via the RHCS.

Monitoring

- Periodic monitoring of potentially exposed individuals quarantined in their homes will be conducted by LPHA/LHDs via telephone or by home health agencies, visiting nurses and other appropriate staff. Quarantined individuals will be instructed to contact public health officials should symptoms of disease develop.
- LPHA/LHDs will work closely with local EOCs and volunteer organizations to provide food, water, medication, personnel care and other items as necessary to individuals quarantined in their homes. The personnel resources of local Fire Departments may also be used to provide such assistance to individuals under quarantine.

- To ensure daily compliance with quarantine, the LPHA/LHDs Epidemiology Division, or their designee (e.g., home health care contractor) will monitor non-vaccinated quarantined contacts daily by a variety of means, including but not limited to home visits or phone calls.

Enforcement

- Quarantine measures may be recommended or mandatory. Voluntary quarantine will be encouraged by the release of emergency information and instructions to the public. The enforcement of mandatory quarantine will be coordinated by LPHA/LHDs and local law enforcement agencies through local EOCs.
- Each jurisdiction is responsible for law enforcement support to enforce isolation and/or quarantine policies and decisions. In the event that exposed or ill persons are unwilling to comply voluntarily with appropriate isolation and/or quarantine measures, law enforcement officials in consultation with LPHA/LHDs staff will be responsible for assuring that these measures are observed to the extent permitted by law.
- The most effective strategy for enforcing quarantines will be to ensure provisions are in place for providing necessary items to individuals quarantined in their homes. Every effort will be made by local government to address such human services issues.
- Depending upon the magnitude and nature of the incident, local law enforcement officials may need state and federal assets to enforce quarantine (i.e., the National Guard). Such requests for assistance will be coordinated and made by local EOCs.

Hospitals

- Hospitals and health care facilities are responsible for appropriate infection control practices, including the isolation and/or quarantine of patients under their care. In a biological event, hospitals will look to local LPHA/LHDs for recommendations and guidance on isolation and/or quarantine measures.
- The isolation of infectious patients is a primary function of hospitals and unless otherwise specified, standard hospital isolation will occur when warranted, based on existing local, state and federal recommendations and guidelines.
- Since there are limited numbers of negative pressure (isolation) rooms available in metro-area hospitals, hospitals may cohort infected patients to expand isolation capabilities. Depending on the number of patients requiring isolation, long term care facilities in the area may be converted to temporary isolation wards using equipment (portable units that create negative air pressure environments).
- According to the Missouri and Kansas Hospital Associations, it is the responsibility of each hospital to ensure the security of the hospital. Local law enforcement may be requested to assist in this effort and will provide assistance if available. For additional information, see Attachment J – Hospitals and Healthcare Systems.

Public Health Surveillance and Epidemiological Investigations

Description:
Public health surveillance and epidemiological investigation is the ability to create, maintain, support, and strengthen routine surveillance and detection systems and epidemiological investigation processes, as well as to expand these systems and processes in response to incidents of public health significance.

This operation consists of the ability to perform and/or coordinate the following functions:

- Coordinate public health surveillance and detection

- Coordinate public health and epidemiological investigations
- Recommend, monitor, and analyze mitigation actions
- Improve public health surveillance and epidemiological investigation systems

A. Coordinating and Cooperating Agencies

- **Coordinating**
  MARC: RHSCC - Public Health Subcommittee

- **Cooperating**
  Local Public Health Agencies
  Medical/Healthcare Organizations (i.e. Hospitals, FQHC)
  School Districts

B. Regional Plans/Strategies

Surveillance

Surveillance is the first line of defense against a biological outbreak and a critical prevention and preparedness activity. Recognizing a public health emergency is the ultimate goal of surveillance. Early recognition of a disease outbreak will allow the timely implementation of treatment and prevention measures to reduce widespread morbidity and mortality.

- LPHA/LHDs in the Kansas City Metropolitan area are responsible for conducting disease surveillance and reporting to the State Departments of Health (DHSS and KDHE). Local and state authorizations as described in local plans, establish the authority of the LPHA/LHDs to accomplish disease surveillance, case investigation and outbreak investigation. Any of these activities may uncover the first indication of a disease outbreak.
- All LPHA/LHDs receive disease reports concerning the communicable and environmental diseases legally mandated as reportable from licensed health care providers, hospitals and laboratories. Many of the LPHA/LHDs in the metro-area monitor surveillance data from local EMS agencies and hospitals through First Watch.
- Effective, ongoing local surveillance requires LPHA/LHDs to develop and maintain good working relationships with those who may identify the first indications of a disease outbreak.
- Successful surveillance further requires LPHA/LHDs in the metro-area to share information on a regular basis (e.g., the bi-weekly conference calls). Some LPHA/LHDs also receive disease reports from veterinarians and syndromic surveillance sites such as schools and major employers.
  - Prevention and preparedness initiatives conducted in the region include weekly regional epidemiology conference calls with the LPHA/LHDs Epidemiology Coordinators and both State Departments of Health. These regular calls strengthen communication lines between jurisdictions and encourage the exchange of epidemiological information that may assist in identifying a disease outbreak.
- The ongoing, passive forms of surveillance conducted by the LPHA/LHDs in the region provide valuable information regarding disease prevalence and the ability to ensure the early recognition and reporting of a potential disease outbreak.
- The LPHA/LHDs in the metro-area work closely with the State Departments of Health (KDHE and DHSS) to monitor disease surveillance data. LPHA/LHDs are provided with information on reportable diseases through their surveillance and reporting systems.

- Missouri and Kansas are currently working on a unified surveillance system compatible for the LPHA/LHDs in both states.

Early Recognition and Enhanced Surveillance

- Any of the ongoing surveillance activities conducted by LPHA/LHDs as described under "Surveillance" may uncover the first indication of a naturally occurring disease outbreak or an unannounced (covert) biological attack. Vigilance for unusual clusters or manifestations of disease is important to the detection of any new infectious disease outbreak and the implementation of enhanced surveillance measures.
- Unusual events are reported to LPHA/LHDs when a hospital, laboratory, EMS agency, school nurse, veterinarian, pharmacy, health care provider or other entity notices an unusual occurrence that suggests a possible bioterrorism event or naturally occurring disease outbreak. LPHA/LHDs are responsible for following up and investigating reports of unusual events, which may lead to the establishment of sentinel surveillance sites.
- Sentinel surveillance sites will be established and maintained by LPHA/LHDs in the event of a suspected or confirmed disease outbreak to gather information regarding morbidity and mortality of disease in the affected jurisdictions. The establishment of sentinel surveillance sites allows for ongoing, two-way communications between LPHA/LHDs and those reporting on disease prevalence.
- The following conditions may warrant enhanced surveillance and the activation of sentinel sites by LPHA/LHDs:

  - Disease outbreaks of the same illness occurring in noncontiguous areas
  - Unusual illness in a population
  - Unusual routes of exposure for a pathogen
  - Large numbers of ill persons with a similar disease or syndrome
  - Large numbers of unexplained disease, syndrome or deaths
  - Higher morbidity and mortality with a common disease
  - Failure of a common disease to respond to routine therapies and treatments
  - Unusual strains or variants of organisms or anti-microbial resistance patterns different from those circulating
  - A single case of an uncommon disease agent such as Smallpox
  - Similar genetic type among agents isolated from distinct sources at different times or locations
  - Higher attack rates in those exposed in certain areas, such as inside a building if released indoors, or lower rates in those inside a sealed building if released outside
  - Disease with an unusual geographical or seasonal distribution
  - Unusual, atypical or genetically antiquated strain or agent identified
  - Disease normally transmitted by a vector that is not present in the local area
  - Endemic disease with unexplained increase in incidence
  - Increased numbers of absenteeism from work and school
  - Increased numbers of dead animals, birds, or insects
  - Multiple simultaneous or serial epidemics of different disease in the same population
  - A disease unusual for an age group
  - A zoonotic disease outbreak (transmission from animals to humans)
  - Atypical aerosol, food, or water transmission or contamination
  - Intelligence of a potential attack, claims by a terrorist or aggressor of a release, or discovery of munitions or tampering
  - Other conditions as identified by LPHA/LHDs

Investigation

Covert Versus Overt Bioterrorism

- An overt bioterrorism event is either announced or detected immediately after the incident. The scene of an overt bioterrorism event will always be treated as a crime scene. Additionally, each victim of a bioterrorism event is considered a crime scene. Two types of overt biological threats should be considered with each requiring a different response by LPHA/LHDs and law enforcement agencies as follows:

    - Overt (observed) threat with likely hoax agent: For example, a package with powder purported to be anthrax. The responding agency will establish command of the incident. A threat assessment will be performed. The LPHA/LHDs will be notified by law enforcement if a sample is taken and sent to the lab for analysis.

    - Overt (observed) exposure with credible biological agent: For example, a plume of material wafts over a group of persons. When the event occurs or after a threat assessment, the material is felt to be a biological agent that can cause adverse health effects. Local law enforcement establishes command and control of law enforcement, and the LPHA/LHDs assumes command and control for health.

- Notification of an overt biological attack will come from local law enforcement agencies to the LPHA/LHDs in the affected jurisdiction, rather than from local surveillance systems. Once notified by local law enforcement, LPHA/LHDs will notify other agencies, as appropriate and needed.
- A covert bioterrorism event is the intentional, but unknown dissemination of an agent. A covert bioterrorism incident may be undetected during the incubation period of the disease. A covert bioterrorism event would first be detected by an increase of common medical symptoms seen by private health care providers and hospitals and reported them to the public health surveillance system. For example, persons become ill after an incubation period and seek medical care at emergency rooms and doctors' offices and their illness is felt to have been caused intentionally (i.e., a bioterrorist attack).
- In a covert event, the source and location of exposure may not be known for some time. In this scenario, law enforcement establishes command and control for law enforcement and the LPHA/LHDs assumes command and control for public health issues.

Event Investigation

- LPHA/LHDs are responsible for following up on any unusual illness, patterns, laboratory results, or other information that suggests an unusual occurrence. When there is sufficient information to suggest an illness is intentionally caused, notification procedures to local, state, and federal law enforcement authorities will be initiated.

Case Investigation

- LPHA/LHDs have primary responsibility for conducting a health or epidemiological investigation. Such investigation includes interviewing patients, assuring that laboratory specimens are obtained and tested, conducting site investigations, and reviewing records and other available data.

- LPHA/LHDs investigations will be coordinated with those of law enforcement, when applicable. Depending upon the magnitude and nature of the incident, LPHA/LHDs investigation teams may be augmented by police investigators, fire fighters, government employees, volunteers and others who are trained at the time of the incident. Requests for state and federal epidemiological support will be made through each jurisdiction's EOC.

Criminal Investigation

- Local law enforcement agencies will be responsible for criminal investigations in their jurisdictions. Law Enforcement agencies will coordinate their efforts with those of LPHA/LHDs and will share any discoveries that could have bearing on the care or treatment of ill or exposed person.
- Local law enforcement agencies have the lead responsibility for law enforcement and will coordinate their efforts with the Federal Bureau of Investigation (FBI). Presidential Decision Directive 39 identifies the Department of Justice as the lead federal agency for crisis management during terrorist attacks involving nuclear, biological, or chemical materials, with the operational responsibility delegated to the FBI.

Threat Assessment

- Upon notification of a suspected or confirmed biological incident, local jurisdictions may convene a team of officials to determine the threat and appropriate course of action. Depending on the event and the jurisdiction, threat assessment may take place in the local EOC or in the LPHA/LHDs Operations Center.
- Jurisdictions will analyze available information and make public health and safety decisions to minimize the spread of illness and loss of life. Every effort will be made to coordinate the threat assessment efforts of the LPHA/LHDs and other applicable organizations/agencies (i.e. law enforcement) in the metro-area. Depending on the event, the threat assessment activities may be coordinated through the use of the RHCS.

Fatality Management

Description:
Fatality management is the ability to coordinate with other organizations (e.g., law enforcement, healthcare, emergency management, and medical examiner/coroner) to ensure the proper recovery, handling, identification, transportation, tracking, storage, and disposal of human remains and personal effects; certify cause of death; and facilitate access to mental/behavioral health services to the family members, responders, and survivors of an incident.

This operation consists of the ability to perform and/or coordinate the following functions:

- Determine role for public health in fatality management
- Coordinate public health fatality management operations
- Coordinate in the collection and dissemination of antemortem data
- Coordinate survivor mental/behavioral health services
- Coordinate fatality processing and storage operations

A. Coordinating and Cooperating Agencies

- **Coordinating:**

Kansas City Mortuary Operational Response Group (KCRMORG)
MARC: RHSCC - Public Health Subcommittee
MARC: RHSCC - Hospital Subcommittee
MARC: Metropolitan Emergency Managers Committee (MEMC)

- **Cooperating**
  Local Medical Examiner or Coroner (ME/C)
  Local Funeral Homes
  Local Public Health Agencies
  MARC: RHSCC – Law Enforcement Subcommittee

B. Regional Plans/Strategies

Attachment G: Regional Mass Fatality Plan and KCRMORG SOP

If the impacted jurisdiction's ME/C determines a need for KCRMORG assistance, requests for activation of KCRMORG should be made in conjunction with the impacted jurisdiction's emergency management director to the Jackson County Medical Examiner's Office (JCMEO). The Jackson County Medical Examiner will assess the incident and determine resource needs and availability for the KCRMORG to support the incident. If the Medical Examiner determines KCRMORG is needed to support the incident, the JCMEO will contact the KCRMORG Commander or Deputy Commanders (as available) to activate the KCRMORG. The KCRMORG Commander/Deputy Commanders will organize and dispatch an initial assessment team to the scene to determine resource and personnel needs. Simultaneously, the Administrative Officer will be notified to issue a standby alert to KCRMORG members for potential deployment. If the impacted jurisdiction is unable to contact the Jackson County Medical Examiner's Office directly, activation requests should be funneled through the appropriate regional mutual aid coordinator. Impacted jurisdictions in Missouri should contact the Region A Mutual Aid Coordinator (Lee's Summit Fire Department) and impacted jurisdictions in Kansas should contact the Johnson County Communications Center. These coordinators will in turn contact the JCMEO.

Biological Incident

- Depending on the event, mass fatalities management considerations in a biological event may include:
    - Establishing temporary mortuary facilities
    - Coordinating interment of the dead and disposition of human remains
    - Coordinating activities and additional resource requests with local EOCs
    - Augmenting local mortuary personnel and resources
    - Obtaining refrigerated space for preservation of human remains
    - Establishing Family Assistance Centers
- Fatalities management in a biological incident may be complicated by contamination and/or the need to isolate human remains. Additionally, law enforcement investigation issues may arise if the fatalities are caused by the intentional release of a biological agent.
- Based on the disease agent and the level of investigation involved, specific guidance on post mortem considerations (including the use of PPE) will be provided to local Medical Examiners by LPHAs with guidance from appropriate state and federal agencies.
- In addition to the guidance provided by LPHAs, the Missouri and Kansas Funeral Director's Associations may be available to provide guidance to local Medical Examiners on the appropriate handling of contaminated human remains.

C. Available Resources to the Region

See Regional Resource Annex: ESF 8

- To support the mission of the KCRMORG, the region — working in conjunction with the Jackson County Medical Examiner's office — has purchased equipment and supplies for a mobile morgue, including a 53-foot refrigerated trailer. The mobile morgue may deploy with and be operated by KCRMORG personnel. With current equipment supplies, and dependent on the condition of remains, the KCRMORG has the ability to process 80 to 100 decedents. State and/or federal support will be required for mass fatality events exceeding these capabilities, or when morgue operations have the potential to extend past two weeks.

- Depending on the incident, the federal resources of the Disaster Mortuary Operations Response Team (DMORT) may be requested to assist local mortuary personnel in addressing special post mortem considerations. DMORT resources are part of the NDMS and if available, they may be requested through local EOCs.

D. Regional Limitations and/or Considerations

- The ME/C is the legal authority for conducting victim identification (or assisting the lead investigative agency to complete victim identification), determining cause and manner of death, and managing death certification. In the event of a mass disaster, the ME/C retains these responsibilities. In mass fatality disasters, no other agency can appropriate these responsibilities. Although KCRMORG provides support to the ME/C to accomplish decedent identification, it cannot speak for the local jurisdiction, nor assume the legal responsibilities of the ME/C. The ME/C retains jurisdictional authority and the KCRMORG team works under the operational control of the local ME/C having legal jurisdiction.

Responder Safety and Health

Description:
The responder safety and health capability describes the ability to protect public health agency staff responding to an incident and the ability to support the health and safety needs of hospital and medical facility personnel, if requested.

This operation consists of the ability to perform and/or coordinate the following functions:

- Identify responder safety and health risks
- Identify safety and personal protective needs
- Coordinate with partners to facilitate risk-specific safety and health training
- Monitor responder safety and health actions

A. Coordinating and Cooperating Agencies

- **Coordinating**
  MARC: RHSCC - Hospital Subcommittee
  MARC: RHSCC - Public Health Subcommittee
  MARC: Emergency Rescue Committee (MARCER)

- **Cooperating**
  Local Public Health Agencies
  Medical/Healthcare Organizations (i.e. Hospitals)
  Local Emergency Medical Services (EMS)

B. Regional Plans/Strategies
Each organization/entity will be responsible for managing their own responder safety and health needs.

Personal Protective Equipment – Administration of Medications

- Personal Protective Equipment (PPE) will be provided to personnel administering vaccines or antibiotics based on recommendations from local, state and federal public health officials. The ICS Safety Officer (either onsite or in the EOC) is responsible for recommending the appropriate use of PPE and proper infection control practices.

- Some LPHA/LHDs in the metro-area maintain a supply of PPE for staff who may be administering medications. Other LPHA/LHDs do not have the ability to maintain their own PPE and will look to local fire departments, EMS agencies and other emergency responders for assistance with PPE requirements for LPHA/LHDs staff.

CBRNE Incident

During a CRNE incident, additional measures will be taken to protect responders and the medical infrastructure. With this in mind, all responding agencies will approach CRNE incidents as a hazmat situation and use appropriate Personal Protective Equipment (PPE). The responding Fire Department will initially serve as the lead agency and appropriately equipped Hazmat Teams will secure the scene, rescue victims and perform victim decontamination prior to direct contact by EMS agencies. In addition, Fire (HazMat) Incident Command will establish safe zones, measure air quality and assess safety hazards to ensure scene integrity before EMS and other responding agencies enter the area.

- In hazmat events, EMS (and other response personnel) will be restricted to environments identified by HazMat Incident Command as suitable for Level D personal protective equipment (PPE). If they are not wearing PPE, response personnel will be restricted to cold zone operations.
- In some CRNE events, it may be difficult to clearly define or maintain safe zone perimeters due to changing winds, uncontrolled movement of contaminated victims, etc. For that reason, EMS agencies in particular are encouraged to provide Level C PPE to their staff.
- Level C protection is not adequate for Exclusion Zone or inner perimeter operations, but would offer a much higher margin of safety for staff working in close proximity to a hazardous environment. Even with a higher level of personal protection, operations, triage, treatment and transportation are safe zone activities.
- The involved Branch Chiefs (e.g., EMS, law enforcement, etc.) will work with HazMat Command to determine the appropriate and safe staging of EMS and other responding agency operations. All crews will be positioned outside the immediate incident site until safe operational zones have been established.

C. Available Resources to the Region
See Regional Resource Annex: ESF 8

Critical Healthcare Facility Protection

A. Coordinating and Cooperating Agencies

- **Coordinating**
  MARC: RHSCC - Hospital Subcommittee
  MARC: RHSCC - Public Health Subcommittee

- **Cooperating**
  Medical/Healthcare Organizations (i.e. Hospitals, FQHCs)
  Local Public Health Agencies
  MARC: RHSCC – Law Enforcement Subcommittee

B. Regional Plans/Strategies

Protection of Treatment Facilities

- In the event of a mass casualty incident, contaminated victims may bypass EMS and self refer to a medical facility creating a risk to facilities and medical personnel. In the event of an incident with this potential, EMS at the scene or LPHA/LHDs will immediately notify nearby medical facilities allowing them to put appropriate security measures in place.
- Once notified, hospitals and other medical facilities will secure their facilities according to their internal procedures. The hospitals in the metropolitan area have developed emergency plans in accordance with state and federal regulations that are tested and exercised regularly in accordance with the Joint Commission for Accreditation of Healthcare Organizations (JCAHO). These plans include procedures for facility protection and restricted access.
- Local Police and County Sheriff's Departments will assist as practical and possible with the protection of health care facilities, as well as securing evidence at medical treatment facilities. For more information on the protection of treatment facilities, see Attachment J – Hospitals and Healthcare Systems.

C. Available Resources to the Region
See Regional Resource Annex: ESF 13

Mental/Behavioral Healthcare

Description:
ESF 8 will coordinate with behavioral health professionals and organizations within the Region to promote behavioral health response and recovery needs. ESF 8 will coordinate with behavioral health, social workers, counselors, substance abuse professionals and community mental health centers, as needed.

A. Coordinating and Cooperating Agencies

- **Coordinating**
  KC Regional VOAD

- **Cooperating**
  MARC: RHSCC - Mental Health and Functional and Access Needs Subcommittee
  Local Public Health Agencies
  Medical/Healthcare Organizations (i.e. Hospitals)
  Local Long-term Care Facilities

B. Regional Plans/Strategies
ESF 6 – Attachment G. Regional Mental Health Response System Plan

Local EOPs describe crisis intervention and mental health services for emergency workers, victims and their families, as well as others in the community needing special assistance in coping with the consequences of an emergency.

- The RHSCC Mental Health and Functional and Access Needs Subcommittee, comprised of mental health professionals and paraprofessionals in the region, meets on a regular basis to address regional mental health coordination issues. This committee has developed protocols for assisting local jurisdictions by providing a system to request and coordinate deployment of trained mental health personnel for emergency situations.

- If needed, the Mental Health Reserve Corps may also be used to augment local capabilities. The Mental Health Reserve Corps includes licensed mental health professionals that may be activated and deployed to assist with disaster mental health, crisis counseling and intervention activities.
- Additional information on these regional mental health resources and procedures for their deployment is included as part of the Regional Coordination Guide (RCG) in RCG: ESF 6 – Mass Care, Emergency Assistance, Temporary Housing and Human Services.

C. Available Resources to the Region
See Regional Resource Annex: ESF 6 and ESF 8

Environmental Health

Description:
Local public health departments may provide (directly or indirectly) environmental health services that help ensure public safety, such as restaurant inspections, food handler training, air quality monitoring and monitoring of hazardous substances such as lead and asbestos. It should be noted that public health department responsibilities will vary.

A. Coordinating and Cooperating Agencies

- **Coordinating**
  MARC: RHSCC - Public Health Subcommittee

- **Cooperating**
  Local Public Health Agencies
  MARC: Environmental Health Work Group

B. Regional Plans/Strategies

Environmental Surety and Clean-up

- While some biological agents pose no hazard in the environment, others may require decontamination procedures, vector intervention and the establishment of a process for safe re-entry into a suspect area.

- When dictated by the agent involved, local jurisdictions will work closely with the appropriate state agencies such as the Missouri Department of Natural Resources (MDNR) and KDHE, as well as federal agencies such as EPA and CDC to implement appropriate actions to ensure conditions in the environment following a biological incident do not pose a health threat to the public.

- LPHA/LHDs in coordination with other local agencies such as Public Works, Parks and Recreation, Water Pollution Control and others will work with state and federal agencies to assess environmental risks and determine anticipated public health threats. Potential public health risks may include:

  - Drinking water supplies
  - Sanitary sewage disposal
  - Vector control

- Air quality
- Food supplies

Vector Control

- If needed, vector control measures will be implemented by local jurisdictions in coordination with state Environmental Health agencies. Vectors that may be involved in a bioterrorism event include insects, rodents, birds and other animals. Local vector control procedures will be implemented in accordance with the vector control procedures described in local Environmental Health Operations Guides.

Animal Remains

- Dead or contaminated animals will be managed by local animal control agencies with support as needed and available from animal control agencies surrounding jurisdictions. Additional resources and personnel to assist with the disposal of dead animals will be requested through local EOCs.
- The Missouri DNR and KDHE, with assistance from their respective State Veterinarians, will provide technical assistance to local animal control agencies regarding the proper disposal of animal remains. It is also expected that these state agencies will provide guidance to local jurisdictions on the potential need for decontamination of vehicles and other equipment used in animal production and transport. LPHA/LHDs with guidance from state and federal agencies will advise local animal control personnel on the use of PPE while handling animal remains.
- The personnel and equipment resources of local hazardous materials teams may be used to support the decontamination process. The equipment of local public works agencies may also be requested to assist with animal burials and/or cremations.

C. Regional Limitations and/or Considerations

The following charts define the various roles and responsibilities of the environmental health functions in the Region.

ENVIRONMENTAL HEALTH QUICK REFERENCE GUIDE

Services provided by:

- Local Public Health Department/Agency
- Environmental Health Division (Not part of HD)
- Other Local Government Division/Agency
- State or Federal Agency
- None of the Above

		MISSOURI								KANSAS		
		CASS	CLAY	JACKSON	LAFAYETTE	PLATTE	RAY	KANSAS CITY	INDEPENDENCE	JOHNSON	LEAVENWORTH	WYANDOTTE
FOOD	Food Handler Training	HD	HD	PW	HD	HD	HD	HD	HD	KDA	KDA	KDA
	Restaurant Inspections	HD	HD	PW	HD	HD	HD	HD	HD	KDA	KDA	KDA
	Tavern Inspections	HD	HD	PW	HD	HD	HD	HD	HD	KDA	KDA	KDA
	Grocery Store Inspections	HD	HD	PW	HD	HD	HD	HD	HD	KDA	KDA	KDA HD
	Convenience Store Inspections	HD	HD	PW	HD	HD	HD	HD	HD	KDA	KDA	KDA HD
	Temporary Food Concession (Permits & Inspections)	HD	HD	PW	HD	HD	HD	HD	HD	KDA	KDA	KDA HD
	Push Cart/Mobile Food Unit (Permits & Inspections)	HD	HD	PW	HD	HD	HD	HD	HD	KDA	•	KDA HD
	Senior Center Inspections	HD	HD	PW	HD	HD	HD	HD	HD	KDA	KDA	HD
	School Inspections	HD	HD	PW	HD	HD	HD	DHSS HD	HD	HD	KDA	KDA
WATER	Private Water Supply Inspections and/or Testing	DHSS	DHSS	DHSS	DHSS HD	DHSS HD	DHSS HD	WD	DHSS	HD	PZ	HD
	Boil Water Order	MDNR	MDNR	MDNR	MDNR	MDNR	MDNR	MDNR	MDNR	KDHE	KDHE	KDHE
	Boil Water Advisory	WD	WD	WD	WD	WD	WD	WD	WD	WD	WD	WD
	Pool/Spa Inspections	HD	HD	•	•	•	•	HD	HD	HD	•	HD

Abbreviations

CD = City Department
DHSS = Missouri Department of Health and Senior Services
ED = Environmental Department
FD = Fire Department
HD = Health Department
KDA = Kansas Department of Agriculture
KDHE = Kansas Department of Health and Environment
KDOA = Kansas Department on Aging
KSE = Kansas State University Extension Service
LE = Law Enforcement
MDNR = Missouri Department of Natural Resources
NCS = Neighborhood and Community Services
NRC = Neighborhood Resource Center
PW = Public Works
PZ = Planning/Zoning
UGHD = United Gov't. of Wyandotte County Health Department
WD = Water Department/District

[1] Independence Services provided by Jackson County HD
[2] Clay County Services provided by Tri-County Health Department
[3] Johnson County Services provided in part by UGHD
[4] Lafayette County Services provided by Pettis County

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		CASS	CLAY	JACKSON	LAFAYETTE	PLATTE	RAY	KANSAS CITY	INDEPENDENCE	JOHNSON	LEAVENWORTH	WYANDOTTE
LEAD	Lead Poisoning Prevention	HD	HD	HD	HD	HD	HD	HD	HD	HD	HD	HD
	Blood Lead-level Testing	•	HD	HD	HD	HD	HD	HD	HD[1]	HD	HD	HD
	Lead Environmental Assessment	•	HD[2]	•	DHSS	•	•	HD	•	KDHE HD	KDHE	KDHE
	Lead Hazard Removal	•	•	•	DHSS	•	•	HD	•	KDHE	KDHE	KDHE
AIR QUALITY	Outdoor Air Quality	MDNR EPA	MDNR EPA	MDNR EPA	MDNR EPA	MDNR EPA	MDNR EPA	HD	MDNR EPA	HD	KDHE	HD
	Radon Monitoring	DHSS	DHSS	DHSS	DHSS	DHSS	DHSS	DHSS	DHSS	KSE	KSE	KSE
	Mold Education	HD	HD	HD	HD	HD	HD	HD	HD	HD	PZ	HD
	Asbestos Monitoring	•	•	•	•	•	•	HD	•	HD	KDHE	KDHE
	Tobacco Control Enforcement	•	•	•	•	•	•	HD	HD LE	LE	LE	LE
WASTE	Septic System Inspections/On-site Wastewater Treatment System	CD	HD	PW	PZ HD	HD	PZ HD	WD	PW	HD	PZ	HD
	Landfill Management/Solid Waste Inspections	MDNR	MDNR	MDNR	MDNR	MDNR	MDNR	MDNR	MDNR	HD	•	•
	Illegal Dumping	LE	PZ	PW	LE	PZ	PZ	LE PW	LE HD	LE HD	PZ	NRC HD

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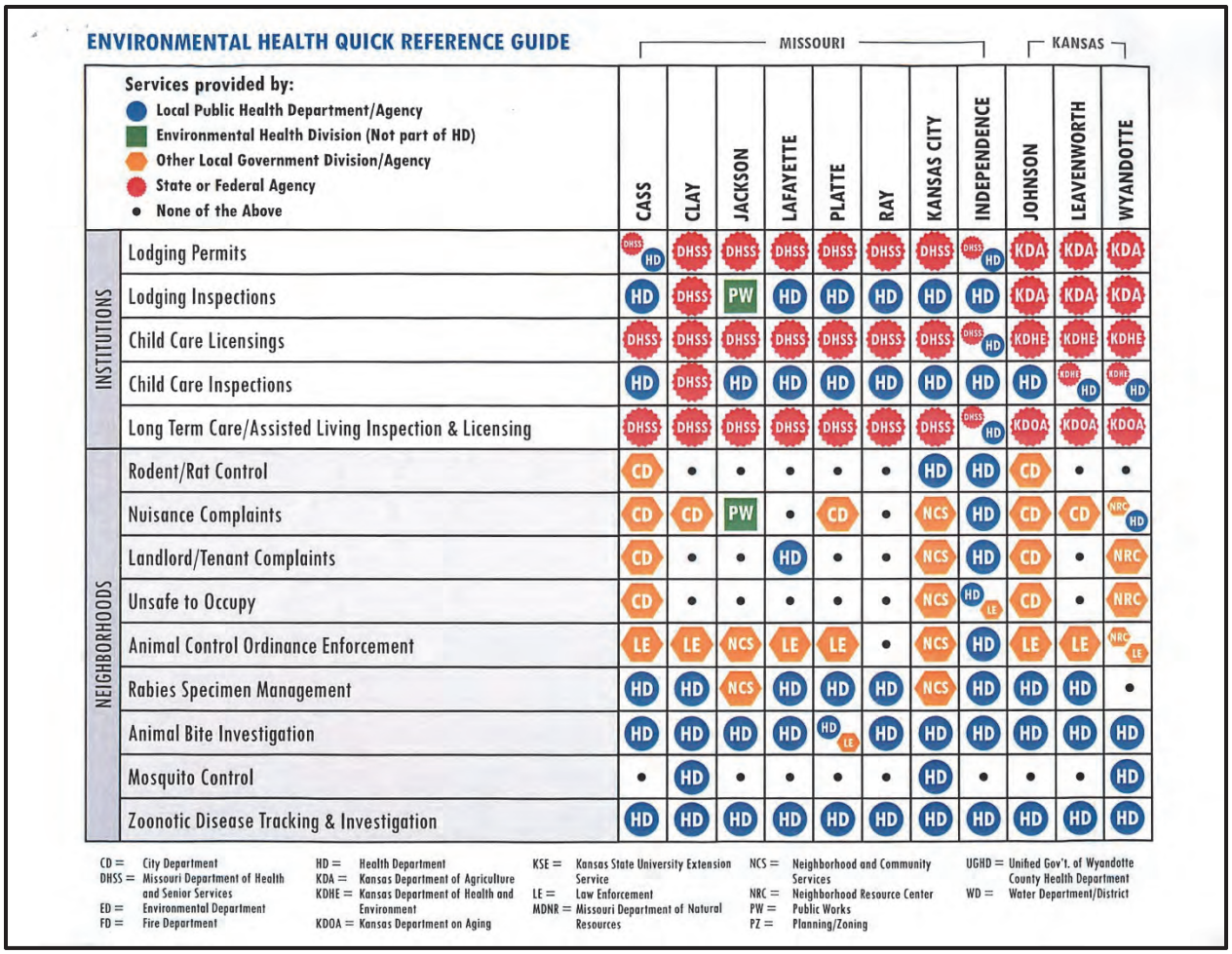

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INSTITUTIONS	Lodging Permits	DHSS HD	DHSS	DHSS	DHSS	DHSS	DHSS	DHSS	DHSS HD	KDA	KDA	KDA
	Lodging Inspections	HD	DHSS	PW	HD	HD	HD	HD	HD	KDA	KDA	KDA
	Child Care Licensings	DHSS	DHSS	DHSS	DHSS	DHSS	DHSS	DHSS	DHSS HD	KDHE	KDHE	KDHE
	Child Care Inspections	HD	DHSS	HD	HD	HD	HD	HD	HD	HD	KDHE HD	KDHE HD
	Long Term Care/Assisted Living Inspection & Licensing	DHSS	DHSS	DHSS	DHSS	DHSS	DHSS	DHSS	DHSS HD	KDOA	KDOA	KDOA
NEIGHBORHOODS	Rodent/Rat Control	CD	•	•	•	•	•	HD	HD	CD	•	•
	Nuisance Complaints	CD	CD	PW	•	CD	•	NCS	HD	CD	CD	NRC HD
	Landlord/Tenant Complaints	CD	•	•	HD	•	•	NCS	HD	CD	•	NRC
	Unsafe to Occupy	CD	•	•	•	•	•	NCS	HD LE	CD	•	NRC
	Animal Control Ordinance Enforcement	LE	LE	NCS	LE	LE	•	NCS	HD	LE	LE	NRC LE
	Rabies Specimen Management	HD	HD	NCS	HD	HD	HD	NCS	HD	HD	HD	•
	Animal Bite Investigation	HD	HD	HD	HD	HD LE	HD	HD	HD	HD	HD	HD
	Mosquito Control	•	HD	•	•	•	•	HD	•	•	•	HD
	Zoonotic Disease Tracking & Investigation	HD	HD	HD	HD	HD	HD	HD	HD	HD	HD	HD

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D. Available Resources to the Region
See Regional Resource Annex: ESF 10 and 11

Recovery

See RCG: ESF 14 – Community Recovery

Local jurisdictions will continue EOC operations as required by the event and as the needs of the incident decrease. Local jurisdictions will gradually return personnel and resource assignments to normal, as appropriate. Long-term recovery activities may necessitate the reassignment of personnel to accomplish ongoing recovery and restoration activities (i.e., infrastructure repair, debris disposal, etc.)

- Local governments will coordinate with the appropriate state and federal agencies to conduct ongoing sampling and monitoring to ensure continued levels of sanitation and/or environmental surety as dictated by the incident.
- Communication and coordination between local governments will continue as needed throughout the recovery phase. The Region will assist local governments with recovery activities as requested and dictated by the event.

- Following an event, specialized equipment and pharmaceutical supplies will be inventoried and restocked. Maintenance and replacement of these supplies is the responsibility of the agency maintaining the resources.
- When appropriate, the Region will work with the involved jurisdictions during the recovery phase to develop a regional after action report detailing the strengths of emergency response activities and identifying areas in need of improvement. The Region will assist local jurisdictions in addressing the actions deemed necessary for improved response operations and regional coordination.
- With assistance from the appropriate plan stakeholders, MARC will review regional plans and procedures for modifications based on lessons learned during response and recovery, including revising and/or updating ESF 8. Further, MARC will review the need to conduct additional training and exercises to improve future response activities.
- When appropriate, the Region will work with local jurisdictions to facilitate prevention and mitigation initiatives to eliminate or minimize the effects of future incidents. To the extent possible and practical, local governments will participate in these activities and address mitigation/prevention actions in their jurisdictions.
- If necessary, local governments will request federal disaster assistance through their respective state agencies. Local governments will work closely with state and federal agencies to administer and coordinate disaster assistance programs. In the event of a Presidential disaster declaration, local jurisdictions and MARC will coordinate with state and federal officials using the organizational structures described in the NIMS and the NRF.

VI. ORGANIZATION AND ASSIGNMENT OF RESPONSIBILITIES

For a list of specific roles and responsibilities, see ***Section V. Concept of Operations: Coordinating and Cooperating Agencies***.

Coordinating Agencies

A. The Coordinating Agencies are tasked with working to ensure regional coordination by:

1. Maintaining ongoing communications with other jurisdictions, such as conference calls and meetings to help ensure regional coordination.
2. Considering the potential pooling of local resources to meet the needs of functional and access needs populations.
3. Initiating communications with other jurisdictions regarding the availability of resources to support ESF 8 operations.
4. Working to ensure consistent and useful emergency public information is released by all of the jurisdictions involved in ESF #8 activities.
5. Providing information to state and federal agencies regarding the need for additional resources to support ESF #8 activities.
6. Coordinating the activities of the Cooperating Agencies to ensure regional issues are considered during ESF #8 operations.
7. Encourage the Cooperating Agencies described below to participate in all regional coordination activities.

Cooperating Agencies

A. As needed, the Cooperating Agencies may provide resources, personnel and special expertise to support ESF #8 activities. The Cooperating Agencies are tasked with working to ensure regional coordination by:

1. Communicating with the Cooperating Agencies in other jurisdictions regarding ESF #8 related issues.
2. Considering the potential pooling of local resources meet a regionally identified need.
3. Participating in regional coordination activities, such as conference calls and meetings.

4. Maintaining communications with agencies in other jurisdictions regarding the availability of resources to support ESF 8 activities.

5. Working to ensure consistent and useful emergency public information is provided regarding agency activities and coordinating the release of information with the other jurisdictions in the region.

ORGANIZATION	RESPONSIBILITIES
MEDICAL/HEALTHCARE ORGANIZATIONS	• Activating individual disaster plans, including planning for the transfer or evacuation of patients to similar facilities; spontaneous volunteers; and staff credentialing • Establishing extended emergency department capacity at or near the facility • Providing medical surge capacity • Providing patient tracking within the hospital and during patient forwarding activities • Establishing decontamination corridors for spontaneous arrivals • Providing situation status reports • Coordinating with other providers and public health departments regarding treatment protocols for unusual incidents or agents • Maintaining hospital infrastructure utilities for sustained function during emergencies • Performing disease surveillance and reporting.
MARC: RHSCC – MENTAL HEALTH AND FUNCTIONAL NEEDS SUBCOMMITEE	• Coordinate resources and advise on mental health and functional access needs issues in the region.
MARC: ENVIRONMENTAL HEALTH WORKGROUP	• Coordinate resources, as needed, and advise on environmental issues in the region.
EMERGENCY MANAGEMENT AGENCIES	• Activate the EOC and implement the EOP in support of ESF 8 • Coordinate the activities of other local departments, agencies and volunteer organizations to support ESF 8 • Ensure the necessary logistical and resource support is provided to ESF 8 • Coordinate with hospitals to ensure adequate technology is available to ensure ongoing communications during an event (e.g., WebEOC) • Coordinate with the state emergency management agencies to ensure the timely request of state and federal assistance to support mass casualty operations
LOCAL PUBLIC HEALTH AGENCIES (LPHA/LHDs) *Most county public health departments are county-level agencies responsible for providing services to all cities within a county and to populations in unincorporated areas.*	• Epidemiological investigation and disease control in the general or specific populations • Long-term health surveillance for communicable disease and disease secondary to an incident involving bioterrorism • Dispensing and administration of mass prophylaxis antibiotics and vaccines • Coordination with hospitals • Isolation and quarantine activities • Implementing social distancing measures • Decisions to protect the general population, such as whether to evacuate or shelter in-place, and regarding first responders sent to an incident that might have involved the use of harmful biological incidents

	• Health alerts, warnings, and the dissemination of information to the public and health care providers • Coordination with hospitals regarding treatment protocols for unusual agents or events • Coordination with the medical examiner/coroner for burial permits and safe handling of the deceased following exposure to harmful biological agent(s). • Assurance of food safety • Vector control (not all LPHAs) • Drinking water safety • Monitor the EMSystem and WebEOC; provide appropriate input and feedback to ESF 8 partners
LAW ENFORCEMENT	• Provide security assistance to medical facilities and to health and medical field personnel upon request • If necessary, provide crowd control, traffic flow and parking assistance around hospitals and other health and medical facilities • Provide for emergency health services at correctional facilities, if appropriate and necessary
FIRE DEPARTMENTS	• Serve as the lead agency for decontamination in the field and provide assistance with decontamination at local hospitals upon request
EMERGENCY MEDICAL SERVICE (EMS) AGENCIES	• Coordinating with in-patient and emergency care providers • On scene triage, treatment, and stabilization • Activating field treatment sites • Transporting and tracking patients transported through EMS • Assigning patients to available hospital services • Surge implementation throughout the medical system May also assist with: • Evacuation of in-patient medical facilities • Coordinating the establishment of alternate care sites • Developing and implementing care protocols for unusual agents or events • Transporting patients that must be quarantined or isolated • Emergency support of mass dispensing sites, evacuation shelters, and quarantine centers • Provision of specific antidote treatments in contaminated areas by specially trained and equipped EMS personnel • Coordination of other disaster and medical health resources.
MEDICAL RESERVE CORP	• Provide supplementary medical and nursing aid and other health services, when requested and within capabilities
LOCAL MEDICAL EXAMINER OR CORONER	• Provide mass fatality support in emergency/disasters
KC FUNERAL DIRECTORS ASSOCIATION	• Provide mass fatality support in emergency/disasters
LOCAL FUNERAL HOMES	• Provide mass fatality support in emergency/disasters
SCHOOL DISTRICTS	• When a reportable communicable disease is confirmed or suspected among students, faculty, and staff members, coordinate with LPHA/LHDs as appropriate
KC REGIONAL VOAD	• Coordinate volunteer agencies and support services, as applicable

Other Agencies

ORGANIZATION	RESPONSIBILITIES
DHSS/KDHE	• Maintain contact with LPHA/LHDs • Activate state public health resources to assist local jurisdictions • Provide technical assistance and guidance as required to LPHA/LHDs • Assist with the forward movement of patients outside the metropolitan area

VII. ADMINISTRATION & FINANCE

A. In order to assess the total impact and damage to a jurisdiction, all ESF 8 participating agencies and organizations (including NGOs and volunteers) will maintain the necessary administrative and financial documentation of costs and expenditures. See RCG: Base Guide - Admin and Finance.

VIII. ATTACHMENTS

Attachment A: Regional Coordination Guide Summary
Attachment B: First Hour Checklist
Attachment C: Regional Healthcare Coordination Guide
Attachment D: MARCER MCI Plan
Attachment E: Community Plan for Ambulance Diversion for the Greater Kansas City Metropolitan Area
Attachment F: MARCER Regional High Demand Plan
Attachment G: Regional Mass Fatality Plan and KCRMORG SOP
Attachment H: Kansas City Metropolitan Area National Disaster Medical System (NDMS) Plan
Attachment I: Kansas City Regional Patient Movement Plan
Attachment J: Kansas City Regional Hospital and Healthcare Systems
Attachment K: EMSystem Protocols and Policies Manual
Attachment L: Hospital Closed Point-of-Dispensing (POD) Plan for Medical Countermeasures
Attachment M: MEMS Guide
Attachment N: WebEOC
Attachment O: Healthcare Related MOUs
Attachment P: Technologies and Systems Overview
Attachment Q: Protocol for Regional News Releases

Regional Resource Annex
The following ESF 8 related items are maintained in the Regional Resource Annex.

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ESF 8 ATTACHMENT A

ATTACHMENT A:

Regional Coordination Guide Summary

ATTACHMENT A. REGIONAL COORDINATION GUIDE SUMMARY

I. Overview

- The RCG provides an overall framework for regional coordination activities and may be initiated and maintained when there is a need for the jurisdictions in the metro area to provide common messages, and share information and resources.

- The protocols described in the RCG are intended to assist participating jurisdictions, agencies and organizations (whether government, volunteer or private sector) in augmenting their emergency resources and maximizing their emergency capabilities.

- The RCG is not intended to be an operational document. Operational emergency activities are coordinated through local Emergency Operations Centers (EOCs) and described in local Emergency Operations Plans (EOPs), standard operating guides, and the operating procedures maintained by local emergency response agencies.

- The RCG is flexible and scalable and was developed for use during any type or size of incident or event. Use of the principles and actions described in the RCG will be determined by the incident or event and the needs of the involved jurisdictions, agencies and organizations. Furthermore, the RCG is applicable for both planned events (i.e. MLB All-Star Game), which are scheduled nonemergency activities; and incidents (i.e. natural and manmade hazards), which are occurrences that require a response to protect life and property. Because events can sometimes turn into incidents, and because regional coordination may be needed in both instances, the application and use of these terms and their meaning throughout the RCG may be interchangeable and are not necessarily mutually exclusive.

- Local participation in the activities described in the RCG is voluntary. Therefore, the RCG represents a voluntary agreement among participating organizations, and as such, no participating organization has "control" or authority over another participating organization except where stated elsewhere in federal, state or local laws.

II. Key Concepts & Organizations

Some disaster events may overwhelm the resources of a single jurisdiction or impact multiple jurisdictions within the region, necessitating assistance from regional partners or collective decision-making to meet the needs of the situation. The **Regional Coordination Guide** (RCG) was developed to document and outline these protocols for regional action in order to maximize the sharing and coordination of information and resources and to improve the surveillance, early detection and mitigation of hazards and threats. These regional protocols can be best understood to comprise a **Regional Coordination System** (RCS). The RCS is a comprehensive concept to describe the mechanisms for how planning and response occur on a regional level, and to ensure the efforts of jurisdictions impacted or potentially impacted by a disaster are appropriately inter-connected and complementary, rather than duplicative. It reinforces interoperability among area jurisdictions and organizations, and makes response efforts more efficient and effective by coordinating available resources, services, and aid.

Furthermore, another foundational component of the RCS is the Regional Incident Coordination Group (RICG). This group is meant to be adaptable and scalable to any incident/event, and will serve as the primary coordinating body during a significant disaster event necessitating regional coordination. The nature of the incident/event and corresponding and evolving response and recovery needs will largely determine which participants will make up the RICG at any given time during the incident/event.

KEY CONCEPTS

Resources:
Resources are defined as personnel, vehicles, established teams, equipment, supplies and facilities available for assignment.

Impacted Jurisdiction(s):
The area defined as the "Impacted Jurisdiction" encompasses the jurisdiction and all the political subdivisions located within that jurisdiction, including special districts. The "Impacted Jurisdiction" is the jurisdiction that has or will be adversely impacted by an incident/event.

Assisting Jurisdiction(s) and/or Disciplines:
The Assisting Jurisdiction and/or discipline(s) provides timely emergency resources, services, and manpower to the Impacted Jurisdiction(s) -- and in some cases, the Host Jurisdiction -- in accordance to the provisions set forth by the RCS.

Host Jurisdiction(s) and/or Facility:
In situations where evacuation and/or mass care operations are necessary, the Host Jurisdiction serves as the jurisdiction that receives and shelters residents and animals coming from the Impacted Jurisdiction(s), and provides mass care and other needs as appropriate.

Regional Incident Coordination Group (RICG): This group is meant to be adaptable and scalable to the incident/event. The nature of the incident/event and corresponding and evolving response and recovery needs will largely determine which participants will make up the RICG at any given time during the incident/event. Specifically, the RICG may be comprised of those designated representatives from the Impacted and Assisting/Host jurisdictions' key leadership, emergency management, first responder disciplines (i.e. Law Enforcement, Fire, EMS, SAR, HAZMAT), public health/medical, other regional disciplines, nongovernmental organizations, and ESF representatives (i.e. Transportation, Mass Care, Communications, Public Works, etc.). Other groups and organizations may be included, depending on the type and scale of the incident.

III. Activation & Initiating Regional Coordination

Although the criteria for initiating regional coordination are subjective, the Regional Coordination System (RCS) encourages a proactive approach to enhance regional vigilance/surveillance, information sharing, and, if necessary, a coordinated approach to incident/event management.

- Activation procedures may vary depending on the nature of the incident/event. The activation of the RCS, as the Regional Coordination Levels below indicate, are only meant to provide possible courses of action that can easily be adapted to the situation.

Pre-Planned Events
For pre-planned events, the decision to utilize components of the RCS will vary. However, because the RCS is scalable and flexible, the Region can utilize the RCS as long as it is not in conflict with existing laws and/or agreements between all of the involved parties.

The RCS may be activated:

- When planning for large or high profile public gatherings that affect multiple jurisdictions.
- When similar past events have required multi-agency coordination within the Region.

Notice and No-Notice Incidents (Hazards and Threats)

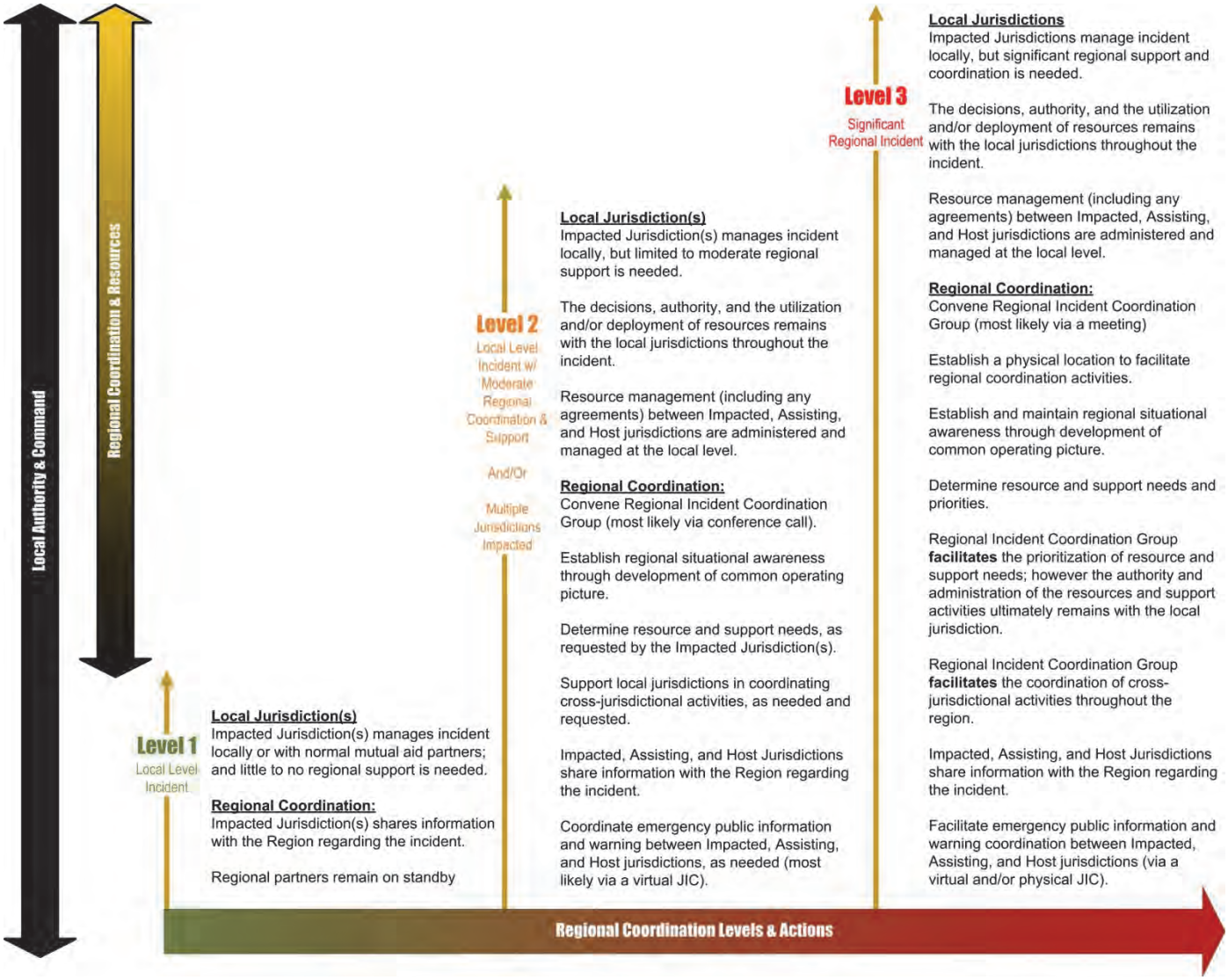
The RCS may be activated:

- When an impacted local jurisdiction's chief executive OR designee initiates the activation of the RCS.
- During a Level 1, 2, or 3 Regional incident/event. (i.e. When there is the possibility or reality that more than one jurisdiction could become involved in the incident response and recovery)
- When the incident could expand rapidly and involve cascading events.

IV. Implementing Regional Coordination: Regional Coordination Levels

The type, scope and nature of the incident/event will dictate when it has regional significance and when regional coordination activities are initiated. Regional coordination within the RCS can be understood to occur across three "levels". The levels are meant to illustrate how regional coordination activities should increase in operational function and complexity as the magnitude or severity of incidents increases. The levels are not meant to be concrete with distinct transition points from Level 1 to Level 2 to Level 3, but rather are defined by planning considerations to generally describe how regional coordination needs and activities differ with the scale of an incident. The figure below provides a summary of key actions for each level. For specific information and detail, see RCG: Base Guide.

(Note: For specific actions for each level, see RCG: Base Guide.)



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ESF 8 ATTACHMENT B

ATTACHMENT B:

First Hour Checklist

ATTACHMENT B. ACTIVATIONS AND ACTIVITIES FOR REGIONAL EMERGENCIES – PUBLIC HEALTH AND MEDICAL SERVICES

The following actions should be carried out as needed based on the specifics of the incident by local officials tasked with responsibilities for accomplishing emergency functions. The **RCG: Base Guide** includes an initial checklist of actions for all emergency functions and discusses the immediate actions for situational awareness, gaining regional awareness, overall response status, and emergency public information (see **RCG: Base Guide)**.

The following tables define the applicable "actions" by **scenario** (CBRNE or Disease/Biological) as it relates to ESF 8.

INITIAL ACTIONS BY SCENARIO	APPLICABLE ACTIONS
Initial Actions for CBRNE Incident	✓ **Mass Casualty** ✓ **Medical/Healthcare Facility Evacuation** ✓ **Medical/Healthcare Coordination** ✓ **Alternate Care Site Coordination** ✓ **Responder Safety and Health**
Initial Actions for Outbreak of Disease/Biological Incident	✓ **Surveillance** ✓ **Public Health Laboratory Testing** ✓ **Mass Casualty** ✓ **Quarantine and Isolation** ✓ **Mass Dispensing** ✓ **Alternate Care Site Coordination** ✓ **Responder Safety and Health**

Source: The following was adapted from the San Francisco Regional Coordination Plan

INITIAL ACTIONS BY SCENARIO: CBRNE INCIDENT
CHEMICAL – RADIOLOGICAL INCIDENT – HOUR 0 TO 8
SITUATION/STATUS INFORMATION
• Type of Incident (localized versus widespread, terrorism bomb blast with chemical or radiological injuries and deaths, or accidental chemical or radiological release) • Affected Area and Population(s) • Hospital Status in the Region (HAvBED polling)

- Medical/Healthcare Facility (i.e. Hospital, FQHCs) Evacuations (under way or complete)
- Medical/Healthcare Infrastructure Support Needed (fuel, water, structural repair, etc.)
- Number and Location of Established Field Treatment Sites
- Number and Location of Established Alternate Care Sites
- Environmental Hazards and No-entry Zones
- Functional and Access Needs Populations
- Equipment (Medical and Non-Medical) Needed for Treatment of Injuries (e.g., radiation sickness, burns, ventilators, responder safety and health (PPE))
- Personnel/Staffing Shortfalls
- Deployment of Local Medical Caches (in progress or complete)
- Mutual Aid Requests in Progress
- Declarations of Emergency (state and local)
- Communications Capability and Instructions
- Availability of Transportation Resources

INITIAL COORDINATION ACTIONS TO SUPPORT REGIONAL RESPONSE	
ACTIONS/DECISIONS	**REGIONAL PLANS**
• Activate RHCS, as appropriate	• ESF 8 – Public Health and Medical Services: ConOps • Attachment C: Regional Healthcare Coordination Guide
• Establish field treatment sites and alternate care sites, as appropriate • Mass casualty operations – Patient tracking and recordkeeping	• Attachment D: MARCER MCI Plan • Attachment F: MARCER Regional High Demand Plan
• Medical surge operations • Establish/Maintain hospitals and alternate care sites • Hospital evacuation, as needed • Hospital coordination, as needed • Patient forwarding, as needed • Bed availability	• Attachment H: Kansas City Metropolitan Area National Disaster Medical System (NDMS) Plan - DMATs (medical staffing) • Attachment I: Kansas City Regional Patient Movement Plan • Attachment J: Kansas City Regional Hospital and Healthcare Systems • KC Regional Evacuation Plan
• Medical materiel management and distribution, as needed and appropriate o Request Strategic National Stockpile, as appropriate	• Attachment L: Hospital Closed Point-of-Dispensing (POD) Plan for Medical Countermeasures
• Maintain safety and security	• ESF 13 – Public Safety and Security
• Responder safety and health o Decontamination and Personal Protective Equipment (PPE) • Provide PPE recommendations • Ensure decontamination processes at hospitals are similar throughout the region	• ESF 10 – Oil and Hazardous Materials
• Public information/Risk communication and Information Sharing • Coordination of information from Terrorism Early Warning (TEW) Group, as needed.	• ESF 15 – Emergency Public Information • Special Incident Annex #2 – Terrorism Incidents
ACTIONS AFTER INITIAL RESPONSE AND INTO HOURS 8 TO 48+	
• Mass fatality (morgue) • Functional and access needs populations • Address mental/behavioral healthcare needs • Address/Coordinate environmental health concerns o Environmental/Sanitation/Water	• Attachment G: Regional Mass Fatality Plan and KCRMORG SOP • Attachment H: Kansas City Metropolitan Area National Disaster Medical System (NDMS) Plan

INITIAL ACTIONS BY SCENARIO: DISEASE OUTBREAK/BIOLOGICAL INCIDENT	
DISEASE OUTBREAK – HOUR 0 TO 8	
SITUATION/STATUS INFORMATION	
• Type of Incident (bioterrorism, pandemic, outbreak of disease in the region)* • Affected Area and Population(s) (nationwide) • Hospital Status in the Region (HAvBED polling) • Number and Location of Alternate Care Sites Established • Functional and Access Needs Populations • Equipment (Medical and Non-Medical) Needed for Treatment of Specific Disease Agent and Shortfalls • Personnel and Staffing Shortfalls • Deployment of Local Medical Caches (in progress or complete) • Mutual Aid Requests (in progress) • Disease Control Measures Under Consideration by Public Health (e.g., mass prophylaxis, isolation, quarantine, social distancing, Public Health Laboratory Testing and Public Health Surveillance and Epidemiological Investigation) • Emergency Declarations and Local Health Directives • Communications Capability and Instructions • Availability of Transportation Resources (for the above)	
INITIAL ACTIONS TO SUPPORT THE REGION	
ACTIONS/DECISIONS	**REGIONAL PLANS**
• Activate RHCS, as needed	• ESF 8 – Public Health and Medical Services: ConOps • Attachment C: Regional Healthcare Coordination Guide
• Medical Surge Operations • Mass Casualty Operations – Patient Triage, Tracking and Recordkeeping • Hospital coordination, as needed • Patient forwarding, as needed • Bed availability	• Attachment D: MARCER MCI Plan • Attachment F: MARCER Regional High Demand Plan • Attachment I: Kansas City Regional Patient Movement Plan • Attachment J: Kansas City Regional Hospital and Healthcare Systems
• Epidemiological Investigation/Laboratory	
• Medical Materiel Management and Distribution o Request Strategic National Stockpile, as appropriate • Non-Pharmaceutical Interventions o Disease Control o Isolation and Quarantine • Responder Safety and Health o PPE • Medical Countermeasure Dispensing o Mass Prophylaxis/Dispensing	• Attachment L: Hospital Closed Point-of-Dispensing (POD) Plan for Medical Countermeasures
• Coordinate/Maintain safety and security	ESF 13 – Public Safety and Security
• Public Information/Risk Communication and Information Sharing	ESF 15 – Emergency Public Information
ACTIONS AFTER INITIAL RESPONSE AND INTO HOURS 8 TO 48+	
• Mass Fatality (morgue) operations • Functional and Access Needs Populations • Alternate Care Sites • Address Mental/Behavioral Healthcare needs • Address/Coordinate environmental health concerns	• Attachment G: Regional Mass Fatality Plan and KCRMORG SOP • Attachment H: Kansas City Metropolitan Area National Disaster Medical System (NDMS) Plan • ESF 6 - Regional Mental Health Response Plan

The following are "**all hazard**" functions that may be adapted and/or utilized during a health/medical incident.

MASS CASUALTY

COLLECT INFORMATION/ASSESS SITUATION

- ☐ Convene a conference call/meeting when status reports indicate a need for regional coordination/assistance.
- ☐ Gather status and requirements from impacted jurisdictions via phone calls or situation reports:
  - Number and types (injury, illness, burns, chemical, radiological exposure, respiratory, cardiac arrest, enteric illness) of casualties in each jurisdiction
  - Number of field treatment sites activated or under consideration
  - Number of alternate care sites activated or under consideration
  - Facility or site status and problems
  - Hospital status and problems (HAvBED polling)
  - Staffing status/problems
  - Security status/problems
  - Transportation status/problems for mass casualty response
  - Equipment/supplies status/problems
  - Public information status
  - Patient tracking issues
  - Functional and access needs population status/problems

COORDINATE RESOURCES TO SUPPORT MASS CASUALTY OPERATIONS

- ☐ Support/Coordinate resource needs:
  - Coordinate provision of resources

PROVIDE CONSISTENT PUBLIC INFORMATION FOR MASS CASUALTY RESPONSE

- ☐ Convene conference call with public information officers (counties, public health, or city public information officers) from affected jurisdictions to coordinate dissemination of common information.

INCIDENT ACTION PLANNING

- ☐ Consider alternate approaches to solve resource shortfalls and optimize use of resources. For mass casualty operations determine whether:
  - There is a need to transfer patients to facilities treating similar illness and conditions
  - The field treatment site is overwhelmed and patients can be forwarded/transferred out of the Region or out of the state
  - Region can assist with the identification of non-traditional facilities for field treatment site or alternate care sites (hotels, vacant offices)
  - Additional support is required for functional and access needs populations

MASS DISPENSING

COLLECT INFORMATION/ASSESS SITUATION

- ☐ Convene a conference call/meeting when status reports indicate a need for regional coordination.
- ☐ Gather mass dispensing status and requirements from jurisdictions via phone calls and/or situation reports:
  - Number of mass dispensing sites activated in each jurisdiction
  - Patient flow rate per hour
  - Hours of operation at dispensing sites and how many to be prophylaxed in next 24 hours
  - Facility types (if these data are needed based on assistance requests)
  - Closed and open POD sites
  - Strategic National Stockpiles status (request from Governor, delivery, the Strategic National Stockpile Receiving, Staging, and Storing Site staging, distribution, security)
  - Staffing status/problems
  - Security status/problems
  - Transportation to dispensing sites status/problems
  - Equipment and supplies status and problems
  - Public information status
  - Functional and access needs population status and problems.

COORDINATE RESOURCES TO SUPPORT MASS DISPENSING OPERATIONS

- ☐ Support/Coordinate resource needs:
  - Coordinate provision of resources

SUPPORT ISSUANCE OF CONSISTENT MEDICAL PROTOCOLS

- ☐ Support public health in issuing consistent orders and medical protocols:
  - Share guidance or directives from the Department of Health and Human Services/CDC and State and Federal officials, including guidance on prioritization of population prophylaxis
  - Distribute legal information to authorities, as appropriate
  - Distribute consistent medical protocols, dosing information, adverse reactions, contraindications, alternative prophylaxis, etc.; consistent medical protocols may be issued by the State(s), the CDC, or other officials

PROVIDE CONSISTENT PUBLIC INFORMATION FOR MASS DISPENSING

- ☐ Convene conference call with public information officers (counties, public health department, or city public information officers) from affected jurisdictions to coordinate dissemination of common information.

INCIDENT ACTION PLANNING

- ☐ Consider alternate approaches to solve resource shortfalls and optimize use of resources. For mass dispensing, determine whether:
  - Dispensing sites can be combined across jurisdictions and whether there are any dispensing sites near jurisdictional borders that can be combined
  - Any dispensing operations are complete and can be accommodated to additional site flow
  - There are any suggestions for additional staffing across jurisdictions within the region; whether non-traditional and unlicensed professionals can dispense
  - Any alternate methods (e.g., drive-through and street delivery) are ready to activate or are in use
  - Public health can reconsider the requirement for targeted or mass population to receive prophylaxis.

QUARANTINE AND ISOLATION

COLLECT INFORMATION/ASSESS SITUATION

- ☐ Convene a conference call/meeting when status reports indicate a need for regional coordination.
- ☐ Gather quarantine isolation status and requirements from affected jurisdictions via phone calls or situation reports:
  - Numbers needing isolation or quarantine in each jurisdiction
  - Type of isolation or quarantine (home, hospital, other facility)
  - Strategic National Stockpile status, if required (request from Governor, delivery, receiving, staging, and storing staging, distribution, security)
  - Legal and court due process status/problems
  - Staffing status/problems
  - Security status/problems
  - Transportation for isolation and quarantine response status and problems
  - Equipment and supplies status and problems
  - Public information status
  - Functional and access needs populations status and problems

PROVIDE RESOURCES TO SUPPORT QUARANTINE ISOLATION OPERATIONS

- ☐ Coordinate with impacted jurisdictions and determine resource needs.

SUPPORT ISSUANCE OF CONSISTENT MEDICAL PROTOCOLS

- ☐ Support local public health organizations with issuance of consistent orders and medical protocols:
  - Convene conference calls to ensure consistent protocols
  - Share guidance or directives from Department of Health and Human Services/CDC and State Public Health and Federal officials
  - Distribute legal information to authorities, as appropriate
  - Distribute consistent medical protocols, which may be issued by the State, the CDC, or other officials.

PROVIDE CONSISTENT PUBLIC INFORMATION FOR ISOLATION AND QUARANTINE

- ☐ Convene conference call with public information officers (counties, public health departments/agencies or city public information officers) from affected jurisdictions to coordinate dissemination of common information.

INCIDENT ACTION PLANNING

- ☐ Consider alternate approaches to solve resource shortfalls and optimize use of resources. For isolation and quarantine, determine whether:
  - Consider combining individuals with similar illnesses or conditions in facilities for isolation or quarantine if this optimizes delivery of support services and use of resources
- ☐ When determining a regional coordination role, consider whether:
  - The private sector (grocery stores and pharmacies) can be mobilized to assist with the delivery of support services during home isolation or quarantine
  - Online shopping (groceries and pharmacies) can be increased and facilitated
  - Telecommuting can facilitate home quarantine
  - There is a need to coordinate with school districts for alternate school arrangements
  - Additional support is required for functional and access needs populations, and what type
  - Mass prophylaxis is occurring simultaneously
  - Law enforcement personnel can be assigned across jurisdictions

MEDICAL/HEALTHCARE FACILITY EVACUATION

COLLECT INFORMATION/ASSESS SITUATION

- ☐ Convene a conference call/meeting when status reports indicate a need for Regional assistance/coordination.
- ☐ Gather status and requirements from impacted jurisdictions via phone calls and/or situation reports:
  - Number of facilities evacuating in each jurisdiction
  - Number of patients and type of beds/level of care required
  - Number of alternate care sites activated or under consideration
  - Coordinate with the State(s) for licensing and certification issues
  - Staffing status/problems
  - Security status/problems
  - Transportation status/problems for evacuation
  - Equipment/supplies status/problems
  - Public information status
  - Functional and access needs populations status/problems
  - Status of medical facilities as potential sites to receive evacuated patients.

PROVIDE RESOURCES TO SUPPORT FACILITY EVACUATION OPERATIONS

- ☐ Contact impacted jurisdictions/facilities and determine resource needs.
- ☐ Coordinate resource needs:
  - Coordinate provision of resources from other organizations/jurisdictions; for example, availability of similar beds and resources so patients can be moved
  - Coordinate provision of resources from other regions
  - Contact private- and public-sector hospital owners/operators for resource availability (hospital beds)

INCIDENT ACTION PLANNING

- ☐ Consider alternate approaches to solve resource shortfalls and optimize use of resources. For medical facility evacuation operations, consider:
  - Whether logistical support can be brought in a timely manner to avoid evacuation
  - Recommend requesting DMATs to assist with care during evacuation and at receiving sites
  - Recommending activation of the National Disaster Medical System
  - The need for transfer of patients to cohort similar illnesses and conditions
  - Whether patients can be sent out of the Region or out of the state
  - Requests for air ambulance transport or military medical evacuation air transportation.

ADDITIONAL INFORMATION FOR MEDICAL/HEALTHCARE FACILITY EVACUATION OPERATIONS

- ☐ Medical/healthcare facilities may be evacuated in situations of significant damage, long-term power outage, and failure of back-up systems. They may be partially evacuated in certain mass casualty incidents or when portions of a facility are required for isolation.
- ☐ The RHCS may become involved when two or more hospitals require assistance to evacuate patients.

COORDINATION WITH ALTERNATE CARE SITES

COLLECT INFORMATION/ASSESS SITUATION

- ☐ Convene a conference call/meeting when status reports indicate a need for Regional coordination.
- ☐ Gather status and requirements from impacted jurisdictions via phone calls and/or situation reports:
  - Number requiring medical care in each jurisdiction
  - Types of medical care needed (dialysis, respiratory, pediatric, elder care, supportive care)
  - Number of alternate care sites activated or under consideration
  - Coordinate with State(s) for licensing and certification issues
  - Facility or site status and problems
  - Staffing status/problems
  - Security status/problems
  - Transportation status/problems for alternate care sites
  - Equipment/supplies status/problems
  - Public information status
  - Level of care consistency across the region

COORDINATE RESOURCES TO SUPPORT ALTERNATE CARE SITE OPERATIONS

- ☐ Coordinate/support impacted jurisdiction resource needs:
  - Coordinate provisions of resources from other regions per existing plans

SUPPORT CONSISTENT PUBLIC INFORMATION FOR ALTERNATE CARE SITES

- ☐ Convene a conference call with public information officers (public health department, counties, or city public information officers) from affected jurisdictions to coordinate dissemination of common information.

INCIDENT ACTION PLANNING – OPTIMIZE RESPONSE OPERATIONS

- ☐ Consider alternate approaches to solve resource shortfalls and optimize use of resources. For alternate care site operations, consider whether:
  - There is a need to transfer patients to cohort similar illnesses or conditions
  - Patients can be sent out of the Region or out of state if alternate care site capacity is overwhelmed
  - Region can assist with the identification of non-traditional facilities for alternate care sites
  - Additional support is required for functional and access needs populations.

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ESF 8 ATTACHMENT C

ATTACHMENT C:

Regional Healthcare Coordination Guide

ATTACHMENT C. REGIONAL HEALTHCARE COORDINATION GUIDE

I. Overview

1. The Regional Healthcare Coordination System (RHCS) Guide was developed for the public health and medical stakeholders in the Kansas City Region.

2. The RHCS Guide is intended to augment and enhance the healthcare coordination system described in ESF 8 – Concept of Operations. The healthcare agencies and organizations in the region may incorporate and/or reference the RCG: ESF 8 – Public Health and Medical Services and RHCS Guide as appropriate in their emergency plans and protocols.

II. Purpose and Scope

1. **Purpose**

   a. In the event of a major incident in the metropolitan area, a Regional Healthcare Coordination System (RHCS) may be established to assist the affected healthcare facilities and facilitate the exchange of information regarding healthcare operations.

   b. The purpose of the RHCS is to accomplish the following:

      i. Establish a mechanism for collecting and disseminating information regarding the availability of and need for healthcare resources, including but not limited to the following:

         1. Equipment
         2. Supplies
         3. Hospital bed capacities
         4. Personnel
         5. Special treatment capabilities
         6. Fatality management capabilities
         7. Transportation capabilities
         8. Alternate care site capabilities

ii. Facilitate the sharing of resources and personnel among healthcare agencies and organizations in the region.

iii. Ensure a unified and coordinated incident management approach among the responding healthcare agencies and organizations in the region.

iv. Provide a structure for healthcare agencies and organizations to communicate and coordinate among themselves, and with others involved in the event.

v. When dictated by the event, coordinate healthcare resources and personnel from outside the region.

vi. Ensure a mechanism is in place for centralized coordination with local, regional, state and federal emergency organizations.

2. Scope

a. The RHCS Guide is intended to support and enhance the emergency plans and protocols maintained by the healthcare agencies and organizations in the region. The guide provides a framework for regional coordination and collaboration during healthcare-related emergency events.

b. The RHCS Guide is designed to complement the regional coordination structure established in the Kansas City Regional Coordination Guide (RCG). The RCG provides overall guidance on how the jurisdictions in the metro-area will coordinate their activities during emergency events of regional significance.

c. The RHCS Guide supports the activities described in the RCG with a focus on coordinating healthcare-related actions.

III. Emergency Activities

Table 1. RHCS Activation Levels & Activities

LOCAL EOC ACTIVATION LEVELS*	LOCAL HOSPITALS AND EMS ACTIVATION LEVELS*	RHCS LEVELS AND CRITERIA	RHCS ACTIVITIES
LEVEL 1: Monitoring operations and low impact emergencies	An Advisory as described in HICS may be issued in the affected facilities A Mass Casualty Incident (MCI) Alert may be issued through the EMSystem (an event with less than 25 patients) and based on daily bed counts, a Level III (low) classification on HEAR	**LEVEL 1** – Regional Healthcare Monitoring An event or situation has occurred requiring the exchange of healthcare- related information to ensure situational awareness among potentially involved agencies; or proactive measures are needed to mitigate the potential effects of an incident, and/or to plan for higher levels of	➢ Proactive information sharing is occurring among the involved agencies and organizations via telephone and using the capabilities of the WebEOC regional situation boards.

	The need to monitor a disease incident or potential disease incident is indicated by LPHA/LHDs, the state(s) or by the metro-area Terrorism Early Warning (TEW) system.	activation potentially required to manage the event; or the need arises to actively monitor a situation occurring in another part of the state or nation with the potential to impact the region.	
LEVEL 2: Moderate to medium impact emergencies	Depending on the event, an Activation as described in HICS may be issued in the affected facilities An MCI Alert or Advisory is issued through the EMSystem (event with 25 – 100 patients) and a Level II (medium) classification on HEAR A disease incident or potential disease incident is reported by LPHA/LHDs, the state(s) and/or by the metro-area TEW	**LEVEL 2** – Regional Healthcare Incident An event has affected a healthcare facility, local public health agency or EMS agency in the region and support is needed from other healthcare providers; or a health and medical emergency has occurred in one or more jurisdictions that requires support from other jurisdictions; or an incident has occurred in another area that requires support from the metro-area Regional Healthcare Coordination System (RHCS)	➢ The Regional Healthcare Coordination System (RHCS) is initiated to share healthcare-related information ➢ There may be a requirement for resource and personnel support from one or more agencies in the metro. ➢ Maintenance of the RHCS will occur virtually via WebEOC, telephone, etc) ➢ Activation of a Regional Healthcare Coordination Center (RHCC) may be considered to support other areas or facilities as needed
LEVEL 3: High impact emergencies and disasters	An Activation as described in HICS is issued in the affected facilities An MCI Advisory is issued through the EMSystem (event with more than 100 patients) and a Level I (high) classification on HEAR A potentially serious disease incident is reported by LPHA/LHDs, the state(s) and/or by the metro-area TEW	**LEVEL 3** – Regional Healthcare Emergency An event has seriously impacted several healthcare facilities and/or agencies in the region and regional coordination is required to provide resources and personnel assistance to the impacted agencies; or an event has overwhelmed local healthcare resources in one or more jurisdictions and regionally available resources are required to manage the event; or an event has overwhelmed local and regional resources and will require state and federal resources to manage the incident.	➢ The incident requires initiation of the RHCS to manage healthcare-related information, resources and personnel ➢ Coordination will occur first using the WebEOC situation boards, and possibly require activation of a Regional Healthcare Coordination Center (RHCC) to provide assistance and support to one or more affected healthcare agencies.

Level 1 Incident

A. During a Level 1 incident, the Impacted Jurisdiction and/or healthcare organization/facility manages the incident locally or with normal mutual aid partners.
- Little to no regional support is expected at this time

B. The impacted jurisdiction(s) and/or healthcare organization(s)/facility(ies) shares information with the Region (ESF 8 Coordinating and Cooperating Agencies, as applicable) regarding the incident.

C. ESF 8: Coordinating and Cooperating Agencies remain on standby.

D. Regional partners initiate appropriate public health and medical activities (i.e. Public Health Surveillance and Epidemiological Investigations), as appropriate, in order to proactively maintain situational awareness; and, if necessary, prepare, prevent, respond, and/or mitigate.

Level 2 Incident

A. During a Level 2 incident, the Impacted Jurisdiction and/or healthcare organization/facility continues to manage the incident locally.

- Moderate regional support may be needed at this time, as multiple jurisdictions and/or facilities may be affected during a Level 2 incident.

B. The impacted jurisdiction(s) and/or healthcare organization(s)/facility(ies) continue to share information with the Region (ESF 8 Coordinating and Cooperating Agencies, as applicable) regarding the incident.

C. In most cases, the impacted jurisdiction(s) and/or healthcare organization(s)/facility(ies) will determine the need to activate the Regional Healthcare Coordination System (RHCS), and will assume responsibility to convene appropriate ESF 8: Coordinating and Cooperating Agencies. In the event the impacted jurisdiction(s) and/or healthcare organization(s)/facility(ies) is overwhelmed, the impacted jurisdiction and/or healthcare organization(s)/facility(ies) may delegate this responsibility.

- Because public health and medical challenges are no longer just local or regional, the RHCS may be initiated by **any** jurisdiction(s) and/or healthcare organization(s)/facility(ies) that has identified an issue (or potential issue) of regional/national significance by calling or e-mailing other coordinating and cooperating agencies in the Region and/or through the use of Web-based information management technology.

D. The impacted jurisdiction, or designee, will declare the RHCS level.

E. During a Level 2 incident, the impacted jurisdiction(s) and/or healthcare organization(s)/facility(ies) will initially arrange a conference call or meeting with other ESF 8: Coordinating and Cooperating Agencies, as applicable, to discuss needed regional coordination actions and develop a specific course of action.

F. If the situation escalates, a **Regional Healthcare Coordination Center** (RHCC) may be activated to provide a central point to coordinate health and medical operations for the Region.

G. Resource management (including any agreements) between Impacted, Assisting, and Host jurisdictions and/or healthcare organization(s)/facility(ies) are administered and managed at the local or organization/facility level, as applicable.

H. Requesting/receiving resources and support is made at the discretion of the Impacted Jurisdiction and/or healthcare organization(s)/facility(ies), which will allow them the ability to select what they need; and, in some cases, for what cost. The Assisting and/or Host Jurisdictions and/or healthcare organization(s)/facility(ies) only have to offer assistance if they have the resources and capabilities. At all times, Impacted Jurisdictions retain the choice of seeking resource support from either state or federal, or both, as may be appropriate for their circumstances.

I. The RHCS will coordinate cross-jurisdictional and/or organizational activities, as needed.

Level 3 Incident

A. During a Level 3 incident, the Impacted Jurisdiction and/or healthcare organization/facility continues to manage the incident locally.

  A. Significant regional support may be needed at this time, as multiple jurisdictions and/or facilities may be affected during a Level 3 incident.

B. The impacted jurisdiction(s) and/or healthcare organization(s)/facility(ies) continue to share information with the Region (ESF 8 Coordinating and Cooperating Agencies, as applicable) regarding the incident.

C. The impacted jurisdiction, or designee, will declare the RHCS level.

D. In most cases, the impacted jurisdiction(s) and/or healthcare organization(s)/facility(ies) will determine the need to activate the Regional Healthcare Coordination System (RHCS), and will assume responsibility to convene appropriate ESF 8: Coordinating and Cooperating Agencies. During a Level 3 incident/event, the need may be obvious and immediate actions should be taken to activate the RHCS. In the event the impacted jurisdiction(s) and/or healthcare organization(s)/facility(ies) is overwhelmed, the impacted jurisdiction and/or healthcare organization(s)/facility(ies) may delegate this responsibility.

E. During a Level 3 incident, the impacted jurisdiction(s) and/or healthcare organization(s)/facility(ies) may initially arrange a conference call with other ESF 8: Coordinating and Cooperating Agencies, as applicable, to discuss needed regional coordination actions and develop a specific course of action.

F. During a Level 3 incident, the Region should strongly consider convening the **Regional Healthcare Coordination Center** (RHCC), if appropriate. This will facilitate improved and timely regional coordination and decision-making, especially in an environment in which situations will evolve and change quickly, resources will be scarce, and life/safety concerns will be at their highest. It is also anticipated that a Level 3 incident will require more than just information sharing and resource coordination, such as in a Level 2 incident.

G. Resource management (including any agreements) between Impacted, Assisting, and Host jurisdictions and/or healthcare organization(s)/facility(ies) are administered and managed at the local or organization/facility level, as applicable. ESF 8, via the RHCS, may facilitate the

prioritization of resource and support needs; however the authority and administration of the resources and support activities ultimately remains with the local jurisdiction.

H. Requesting/receiving resources and support is made at the discretion of the Impacted Jurisdiction and/or healthcare organization(s)/facility(ies), which will allow them the ability to select what they need; and, in some cases, for what cost. The Assisting and/or Host Jurisdictions and/or healthcare organization(s)/facility(ies) only have to offer assistance if they have the resources and capabilities. At all times, Impacted Jurisdictions retain the choice of seeking resource support from either state or federal, or both, as may be appropriate for their circumstances.

I. The RHCS will coordinate cross-jurisdictional and/or organizational activities, as needed.

Regional Healthcare Coordination Center (RHCC)

A. Activation of the RHCC may occur in several ways including, but not limited to:

- The IC(s) of the affected hospital(s) may request activation of the RHCC, when the need arises to coordinate simultaneously with several hospitals, or when facility personnel and equipment capabilities are exceeded.
- A local EOC may request activation of the RHCC to ensure regionally available healthcare resources are available to support local operations. Depending on the event, a healthcare agency representative already in their local EOC may request activation of the RHCC to assist their jurisdiction.
- Local Public Health Agencies (LPHA/LHDs) may request activation of the RHCC to assist in managing a healthcare related event to help ensure information is exchanged among agencies and between jurisdictions.
- EMS agencies may request activation of the RHCC to help with resources identification, or in a major mass casualty incident to ensure information is exchanged among agencies and between jurisdictions.
- As part of the MEMS Guide (see Attachment M), District Healthcare Coordination Centers (DHCC), which are part of a broader plan to address public health and medical needs for the 13 counties in Missouri Region A, may request activation of the RHCC to facilitate coordination between the other DHCCs.

B. The RHCC will provide coordination and support activities, as needed.

1. Establish a mechanism for collecting and disseminating information regarding the availability of and need for healthcare resources, including, but not limited to, the following:

- Equipment
- Supplies
- Hospital bed capacities
- Personnel
- Special treatment capabilities
- Fatality management capabilities
- Transportation capabilities
- Alternate care site capabilities

2. Facilitate the sharing of resources and personnel among healthcare agencies and organizations in the Region.
3. Ensure a unified and coordinated incident management approach among the responding healthcare agencies and organizations in the Region.
4. Ensure a unified incident management approach with the other RCG: ESFs in order to ensure a coordinated regional response and recovery in the Region. Key members representing the RHCC should also participate and/or designate an individual or individuals to represent the public health and medical needs in the Regional Incident Coordination Group (RICG), as appropriate.

    - Key leadership from the *ESF 8: Coordinating Agencies*, as appropriate, will most likely represent the RHCC in the RICG (if activated) during a regional incident/event.

5. Provide a structure for healthcare agencies and organizations to communicate and coordinate among themselves, and with others involved in the event.
6. When dictated by the event, coordinate healthcare resources and personnel from outside the Region.
7. Ensure a mechanism is in place for centralized coordination with local, regional, state and federal emergency organizations.
8. Key positions that may be filled in the RHCC are included in Appendix 3.

Table 2. Regional Healthcare Coordination Center (RHCC)

Facility Name	Address	Max Capacity
Don Chisholm Center: Children's Mercy Hospital Campus	610 E. 22nd St. Kansas City, MO 64108	**8 individuals** Note: Additional training rooms are available
Emergency Operations Centers (EOC) in the Kansas City Region	**Will be determined, as needed.**	

IV. Appendices

1. RHCS Representatives
2. WebEOC Regional Situation Boards
3. RHCC General Position Descriptions

Appendix 1: RHCS Representatives

Maintained by MARC. Contact MARC for a list of Representatives.

Appendix 2: WebEOC Regional Situation Boards

Contact Emergency Management Agencies in each jurisdiction for specific login information to WebEOC.

See Attachment N for the WebEOC Regional Situation Boards for ESF 8.

Appendix 3: Regional Healthcare Coordination Center (RHCC) General Position Descriptions

Facility Manager: Establishes, organizes, staffs and directs the operations of the RHCC. The RHCC Facility Manager will oversee RHCC activities and assist in establishing overall strategies in coordination with the RHCC Liaisons and other local agencies and organizations as appropriate for the event.

Liaison to Public Information Officers (PIOs) and Joint Information Centers (JICs): Serves as the point of contact for all emergency public information activities in the RHCC. This Liaison will work with local PIOs and JICs to ensure consistent messages are developed and released involving the healthcare-related involved in the event.

Liaison to Local Emergency Operations Centers (EOCs): Serves as the point of contact with local EOCs and ensures communications and coordination is maintained between the RHCC and the local EOCs involved in the event.

Liaison to Incident Commanders (IC)/Unified Command (UC): Serves as the point of contact with the IC/UC and ensures communications is maintained between the RHCC and the field and/or affected facility. This Liaison will ensure appropriate RHCC activities are initiated to support field and/or facility activities.

Liaison to Alternate Care Sites (ACSs): Serves as the point of contact with ACSs activated for the event. The RHCC Liaison to ACSs will ensure coordination and communications with ACSs and that RHCC activities are initiated and maintained as needed to support ACS activities.

Liaison to Joint Operations Center (JOC): Established if the FBI activates a JOC to monitor and act on intelligence information related to the event. When needed, this Liaison will work to ensure needed intelligence information is taken into account when performing RHCC activities.

Planning/Resources and Situation Reporting Section Coordinator: Responsible for the collection, evaluation, dissemination, and use of information regarding the event, as well as the status of resources. This position is responsible for developing and disseminating reports and formulating the Action Plan.

Finance and Administration Section Coordinator: Responsible for financial and cost analysis aspects related to the event, including maintaining appropriate documentation of RHCC expenditures (e.g., labor, materials, supplies, etc.). The Finance and Administration Coordinator will assist in development and implementation of the Action Plan as needed.

Logistics Section Coordinator: The Logistics Section Coordinator is responsible for identifying and helping to provide facilities, services, personnel, equipment and other materials in support of the agencies and organizations involved in the event. The Logistics Coordinator will participate in development and implementation of the Action Plan as needed.

2014

BI-STATE

KANSAS CITY REGION

ESF 8 ATTACHMENT D

ATTACHMENT D:

MARCER MCI Plan

ATTACHMENT D. MARCER MCI PLAN

MID-AMERICA REGIONAL COUNCIL
EMERGENCY RESCUE COMMITTEE (MARCER)

REGIONAL MASS CASUALTY INCIDENT PLAN FOR METROPOLITAN KANSAS CITY

April 2015

I. Record of Changes

CHANGE NUMBER	DATE OF CHANGE	CHANGE/COMPLETED BY	DATE COMPLETED
1	July - December 2005	Major Plan Revision MARCER Planning Subcommittee	January 2006
2	April 2006	Minor Plan Updates Planning Subcommittee/MARC staff	May 2006
3	October 2008	Plan Update	October 2008
4	June 2011	Plan Update	June 2011
5	April 2015	Plan Update	April 2015

II. Letter of Promulgation

To All Agencies and Readers:

The Mid-America Regional Council Emergency Rescue Committee (MARCER) has prepared this Regional Mass Casualty Incident (MCI) Plan. The purpose of this plan is to describe the procedures necessary to ensure an effective and coordinated response to an incident involving mass casualties in the Kansas City metropolitan area.

This plan will be reviewed and updated at least bi-annually to reflect changes in policies, technology or operational procedures that affect the emergency response capabilities of the EMS agencies in the greater Kansas City region.

MARCER welcomes your comments and suggestions for improving this plan. Please direct your comments and suggestions to MARCER, 600 Broadway, Suite 200, Kansas City, MO 64105-1554 or via e-mail to MARCER@marc.org.

Brad Mason, Division Chief
Johnson County Med-Act
Chair, Mid-America Regional Council Emergency Rescue Committee

III. Overview

Background

A. The Mid-America Regional Council Emergency Rescue Committee (MARCER) is comprised of emergency medical services (EMS) agencies throughout the nine (9) county Kansas City metropolitan area and has coordinated regional emergency pre-hospital care since the mid-1970s.

B. MARCER addresses mutual aid issues, tracks and advocates for state legislation, manages a regional medical communications system (radio and EMResource), and a cooperative purchasing program for metropolitan Kansas City.

C. In the late 1970's, MARCER developed a regional mass casualty incident plan. The plan provided definitions that became standards for many local agencies and were incorporated by the Greater Kansas City Health Council in their Emergency Communications Plan.

D. In 1997, as part of a regional strategic planning process, MARCER determined the need to develop a new Mass Casualty Incident (MCI) Plan for metropolitan Kansas City. This plan is a result of the efforts of MARCER members to document regional procedures for a MCI incident and provide an official plan for use by EMS agencies throughout the region.

E. Metropolitan Kansas City is fortunate to be served by a sizable number of EMS agencies and hospitals. There are over 39 state-licensed EMS agencies, including EMS departments, fire departments, air ambulance services and other providers. The nine-county, bi-state region is served by 30 major hospitals. A list of these resources is included as **Appendix A**.

F. The MARCER MCI Plan provides a structure for coordination and communications among multiple EMS agencies and other organizations providing pre-hospital emergency care in metropolitan Kansas City. The MCI Plan is designed to maximize existing EMS and hospital resources.

Purpose

A. The purpose of the MCI Plan is to accomplish the following:

1. Increase knowledge and access to available resources.

2. Improve understanding and enhance coordination in the use of the region's various medical communications systems.

3. Standardize equipment and training.

4. Offer consistent definitions for Incident Command System operations at an MCI.

5. To coordinate resources in the event of an MCI, either live or virtual through WebEOC.

6. The use of a regional plan allows for command staff from other agencies to be utilized in the incident organization to fill ICS positions and free up ambulance crews for triage, treatment and transport tasks.

7. Provide direction to EMS agencies, hospitals and others involved in a mass casualty incident in a manner that is consistent and compatible with standard ICS and local emergency plans.

B. The MCI Plan addresses mass casualty incidents occurring in the following counties in metropolitan Kansas City: Cass, Clay, Jackson, Platte and Ray counties in Missouri; and Johnson, Leavenworth, Wyandotte, Miami and Douglas counties in Kansas. All EMS agencies and hospitals serving all or portions of these ten (10) counties or located within these counties are covered by this plan, unless indicated otherwise.

Regional Coordination

A. The Health Alliance of Mid-America maintains the Hospital Emergency and Administrative Radio (HEAR) system, conducts semi-annual hospital drills and provides opportunities for information sharing and cooperation.

B. The Emergency Nurses Association Managers Special Interest Group meets regularly to share information, coordinate training and provide important input to regional emergency medical issues.

C. The Regional Homeland Security Coordinating Committee (RHSCC) Hospital Subcommittee is made up of the emergency preparedness coordinators of area hospitals, and meets regularly to discuss planning and other preparedness activities including those related to mass casualty events. In addition to the MARCER, coordination among area EMS agencies and emergency responders is also accomplished through other RHSCC Subcommittees, such as the Training and Exercise and Plans Subcommittees.

D. The MCI Plan is coordinated with several other regional plans, such as the EMResource Protocols and Polices Manual and the Metropolitan Community Plan for Diversion, both of which were developed by the MARCER. An index of the regional plans with a relationship to the MARCER MCI Plan is included in **Appendix B.**

Definitions

A. Mass Casualty Incident

For purposes of this plan, a mass casualty incident, or MCI, is any single incident that results in a number of patients that overwhelms the responding agency's resources **and** as determined by the Incident Commander. To facilitate situational awareness an incident should be assigned a "level" within EMResource so that other agencies in the region will have an awareness of the scale of the event. The action taken by the initial responding agency will be based on the type of event, extent of the injuries found and the resources available to that agency at that time.

MCI Level Definitions:

Level V is 5-10 patients. If a Level V MCI is declared, one of the three EMResource Control Centers (EMCC) will initiate an MCI Alert through EMResource and conduct a bed poll of the three closest hospitals and the closest trauma center.

Level IV is 10-25 patients. If a Level IV MCI is declared, one of the three EMCC's will initiate an MCI Alert through EMResource and conduct a bed poll of the five closest hospitals and the two closest trauma centers.

Level III is greater than 25 but less than 50 patients. If a Level III MCI is declared, one of the three EMCC's not directly involved in working the event will initiate an MCI Alert through EMResource and conduct a bed poll of all KC regional hospitals and notify all regional EMS agencies via the PS DISP talkgroup on the regional radio system.

Level II is greater than 50 but less than 100 patients. If a Level II MCI is declared, one of the three EMCC's not directly involved in working the event will initiate an MCI Alert through EMResource and conduct a bed poll of all KC regional hospitals and notify all regional EMS agencies via the PS DISP talkgroup on the regional radio system

Level I is greater than 100 patients. If a Level I MCI is declared, one of the three EMCC's not directly involved in working the event will initiate an MCI Alert through EMResource and conduct a bed poll of all KC regional hospitals and notify all regional EMS agencies via the PS DISP talkgroup on the regional radio system. This level will likely involve actions based on other plans such as the National Disaster Medical System or local pandemic plans based on the type of incident or event. This could be a site specific incident or a region wide incident with possible multiple sites which could require significant inter-agency coordination and/or agencies to be self-sufficient.

Incident Management

A. The National Incident Management System (NIMS) will be used to manage MCI incidents in the metropolitan area. As prescribed in NIMS, ICS will be used for incident management.

B. The goal of ICS is to ensure central control, provide for inter-agency coordination and provide that no one individual becomes overloaded with specific assignments or information. On simple incidents, the Incident Commander or Medical Branch Director may well serve multiple roles. The ICS provides the ability to expand or contract the incident organization as needed to manage incident needs and resources.

C. **While this plan does not supplant or dictate local department operations, it encourages all agencies to follow consistent procedures.** The more a system can be used on routine operations, the easier it will be to use on complex MCI's. The ICS is designed to allow even the smallest department to "fill out" the ICS positions on a large incident through the use of mutual aid resources.

D. Users of this plan are encouraged to obtain a copy of the *National Fire Service Incident Management System Model Procedures Guide for Emergency Medical Incidents* (latest version) for detailed descriptions of Incident Command System positions.

E. The standard medical ICS structure for mass casualty incidents is illustrated in Figure 1. **Appendix C** describes some key ICS positions that may be necessary to manage an MCI and **Appendix D** contains a checklist of actions to be performed by each Medical ICS position.

IV. Implementing the Mass Casualty Incident Plan

First Unit On Scene

A. Regardless of the location, nature or extent of the incident, the first unit to arrive on the scene shall have initial command and control responsibility, and should:

1. Assess the scene and check for unusual hazards.

2. Advise the unit's communications center of the situation, including MCI Level, patient count, type of event, hazards, request for resources, ambulance staging location, and ingress and egress.

3. The local communications center should notify the closest EMCC of the MCI Level as appropriate, and request an MCI Alert be issued on EMResource.

4. Mutual Aid needs will be requested based on the local agency's procedures.

5. Establish a command post and announce location. Maintain command and control of the incident until relieved of command.

6. Assign or initiate triage.

7. Establish patient tracking early.

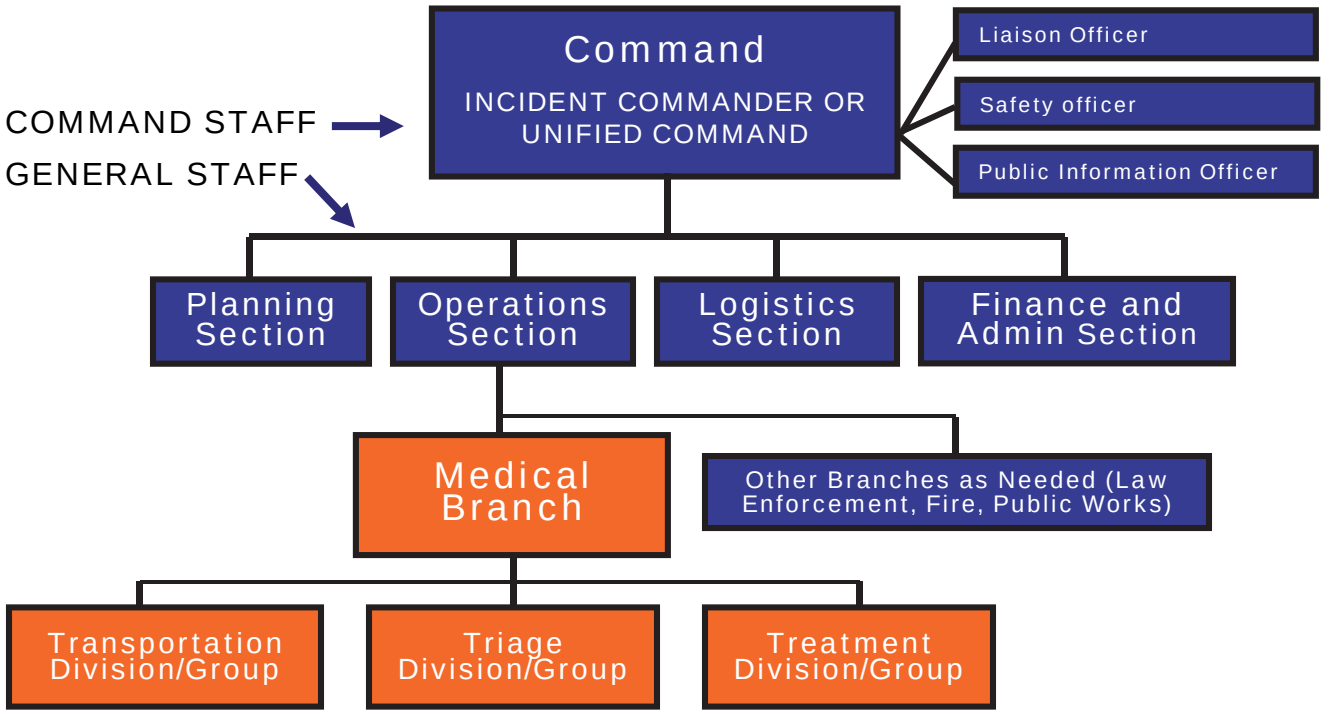
8. If the incident is a Chemical, Biological, Radiological, Nuclear or Explosive (CBRNE) mass casualty event it should be treated as a hazmat scene and if not already on scene, the appropriate hazmat team should immediately be contacted for assistance.

9. If a CBRNE incident, the EMCC should note the need for decontamination and issue a Haz-Mat / MCI Alert in order to poll hospitals for their capability for decontamination.

EMResource Control Centers:

Agency	Phone
Johnson County, KS Emergency Communications	913-432-2121
Kansas City, MO Fire Department Communications	816-923-3456
Lee's Summit Fire Department Communications	816-969-7407

Figure 1: Sample ICS Structure for Mass Casualty Incidents



When contacting mutual aid agencies provide the following:

A. Nature and location of the emergency.

B. Number of personnel requested and type of specialized personnel or equipment needed.

C. Access route to the incident and staging location if established.

D. Appropriate regional communications talkgroup to utilize.

For larger incidents, local mutual aid in Missouri will be coordinated by the Lee's Summit Fire Department through Region A of the Missouri Fire Mutual Aid System (MOSCOPE).

Medical Branch Functions and Personnel

A. The following Medical Branch functions may be established as required for management of an MCI. The positions should be identified by color-coded vests. Functional areas can be identified with flags or other markers.

1. Medical Branch Director (vest).

2. Ambulance Staging Area (flag) *this may be incorporated into the main staging area.*

3. Triage Division/Group Supervisor (vest). Triage Area (flag).

4. Treatment Division/Group Supervisor (vest). Treatment Area (flag and/or colored tarps).

5. Transport Division/Group Supervisor (vest.) Transport Area (flag).

6. Medical Communications (vest).

B. All emergency responders on the scene of the mass casualty incident should wear identification designating their jurisdiction/agency. Key ICS positions should be identified by vests.

Regional Standing Orders for EMS Operations

A. During Mutual Aid operations, each participating agency will follow their own medical protocols at all times.

Use of Helicopters

A. Helicopter support may be a valuable and effective resource in providing timely patient care and transportation, depending on weather conditions, the location of the incident and other factors.

B. When the Medical Branch Director determines that conditions exist for the use of air ambulance services, requests should be routed through the Incident Commander. The communications center will request the appropriate response from air ambulance agencies.

C. An appropriate landing zone will be identified and cleared. The Incident Commander will assign personnel to assume responsibility for establishing the landing zone.

D. After landing, air ambulance medical crews will report to and accept direction from the Medical Branch Director or designee for operational purposes.

Role of Law Enforcement

A. In an MCI, the functions performed by law enforcement may include:

1. Law enforcement officials may be the first responders to the scene of an MCI. The officers should report the nature of the incident to their communications center, which would relay the information to the appropriate EMS or fire communications center.

2. Securing the scene of the incident to prevent additional casualties.

3. Providing traffic control to facilitate movement of emergency vehicles to ensure ingress and egress of ambulances.

4. Preserving a crime scene and incident investigation as appropriate

V. Triage Treatment and Transport Procedures

The purpose of the Regional Triage, Treatment and Transport Procedures is to establish standard practice in the event of a mass casualty incident. The primary objective is to evaluate, treat and transport patients in an effective and expedient manner.

Triage Division/Group

The Triage Division/Group Supervisor is responsible for:

A. The management of victims where they are found at the incident site. Survey the incident area to make a quick evaluation of all injured persons, stopping only to treat airway emergencies and uncontrolled bleeding. On large geographic incidents, such as large buildings, triage may need to be subdivided into geographic divisions.

B. Ensuring the entire area is searched and patients are tracked.

C. Sorting and moving victims to the treatment area, with priority given to red triaged patients.

D. Coordination between extrication/rescue teams and patient care personnel to provide appropriate care for entrapped victims.

E. Color-coded triage tags will be used as early as possible and prior to leaving the scene (see appendix E). The five categories include:

1. **Immediate (RED)** - First priority in patient care, these are victims in critical condition whose survival depends upon immediate care. Treatment and transport of red victims should begin as soon as possible. Do not delay transport if resources are available.

2. **Delayed (YELLOW)** - Victims that need urgent medical attention and are likely to survive if simple care is given as soon as possible.

3. **Minor (GREEN)** - Victims who require only simple care or observation. Even though victims in this category may appear uninjured, they may need to be transported to a medical facility for evaluation.

4. **Morgue (BLACK)** - These victims are dead or whose injuries make them unlikely to survive and/or extensive or complicated care is needed within minutes.

5. **Not injured but need to track (WHITE)** - These individuals are not injured but do require tracking through an identified system. To make their tag White, simply tear off all colored panels to leave the white tag remaining.

Treatment Division/Group

A. A treatment area may be needed for a large incident when many people are injured and transport resources are not immediately available. All patients not immediately transported should be sent from the triage area to the treatment area.

B. The Treatment Division/Group Supervisor is responsible for:

1. Establishing a treatment area which is:

i. In a safe location

ii. Away from the immediate action

iii. Easily accessible for litter bearers and transport units

iv. Large enough to accommodate all patients and medical personnel

v. Defined by colored flags, cones, paint, tarps, and/or light sticks to identify treatment areas and the location of ingress and egress

2. Sorting patients at the treatment area to establish priorities for treatment and transport.

3. Tracking patients.

4. Directing patient care as needed.

5. Notifying the Medical Branch Director of needs for personnel, security, lighting, medical supplies and other equipment.

6. Coordinating and prioritizing patient transport with the Transport Division/Group Supervisor.

7. Coordinating the actions of physicians and/or other medical personnel.

Transport Division/Group

The Transport Division/Group Supervisor is responsible for.

A. Arranging appropriate transport vehicles for patients requiring transport.

B. Securing ambulance ingress and egress route(s).

C. Tracking patients.

D. Communicating with the EMCC to determine hospital availability/capacity.

Movement of Patients Out of the Metro Area

A. Forward Movement of Patients

1. In the event local and regional healthcare resources are insufficient to provide the definitive care required for those affected by the event, patients will be transported to other hospitals outside the Kansas City area. Additional information on the movement of patients out of the metropolitan area is included in the regional coordination guide – ESF8.

VI. Emergency Communications

Radio Identification

A. Only essential radio communications should be made during a mass casualty incident in order to keep radio traffic to a minimum.

B. When communicating during response to a mass casualty incident, all responding units will identify themselves on radio with "Department Name - Unit Type - and Unit Number". For example, **"KCK MEDIC 1 to I-35 COMMAND."**

C. Once a unit is assigned a task, it should identify itself with the Task or Division/Group as appropriate, e.g., "Triage Team 1 to Triage Group." When a task is complete, the unit should report back to the officer that the given task is complete.

D. All communications shall be made in plain language. No "10-codes" will be used.

E. Units using radio communications should first make sure that the receiving unit is ready to copy before sending body of message. The receiving unit should then repeat in summary the body of the message or order.

F. Regional communications system talkgroup names will be used instead of numeric nomenclature.

G. In order to provide for maximum safety and clarity of operation, certain key words must be understood to mean the same to all involved:

i. Withdraw - In an orderly manner, back out of the area taking all equipment with you as you go.

ii. Evacuate/Abandon - Immediately leave area, dropping in place any equipment that would slow down retreat. Personnel accountability must be assured after this command has been given.

iii. All Clear - It has been determined that the hazard to civilians has been eliminated or does not exist. If the hazard level precludes search of involved/threatened areas, an announcement from Command that "No all clear will be given" will be issued. Either announcement signifies that objectives are switching primarily to exposure/confinement operations.

Use of the MARCER Radio System

A. The Medical Communications System (Med Channel) managed by MARCER is a two-way communication system allowing EMS field crews to communicate with Kansas City area hospitals on pre-hospital patient care or to alert the hospitals to in-coming patient situations.

B. The primary backbone for the medical communications system is the Metropolitan Area Regional Radio System (MARRS). Every ambulance and hospital is equipped with a MARRS radio and all communications with hospitals occurs over this radio.

Use of EMResource

A. EMResource is a web-based program providing real-time information on hospital emergency department status, hospital patient capacity, availability of staffed beds and available specialized treatment capabilities.

B. EMResource links all acute care hospitals and many EMS agencies in the greater Kansas City metropolitan area. **This is the region's primary method of communicating hospital status and capabilities and coordinating patient routing during an MCI.**

C. Refer to the *Community Plan for Ambulance Diversion for the Greater Kansas City Metropolitan Area* for detailed information on EMResource and its use.

Use of the HEAR System

** Note: at the time of this documents revision arrangements are being made to designate new Primary and Secondary Control Hospitals. The "Emergency Communication Plan for Hospitals and Emergency Service Providers in the Greater Kansas City Area" is under revision and will need to be adopted prior to the formal agreement being completed by the Primary and Alternate Control Hospitals. Discussions are currently underway as a cooperative effort with MARC, the Missouri Hospital Association and the Kansas City Metropolitan Healthcare Council for the revision of the Document. After the Primary and Alternate Control Hospitals are named they will be listed in the MCI Plan within this section.

In the event of EMResource failure the HEAR system will be utilized in the following manner:

A. The Hospital Emergency Administrative Radio (HEAR) system links all acute care hospitals in metro Kansas City and many area EMS agencies on a single channel radio system (155.340 MHz).

The HEAR system serves as a backup to the EMSystem in the event of an MCI. The Primary Control Hospitals serves as the primary point of contact for the HEAR system.

B. The HEAR system is operated from Primary Control Hospital. The HEAR system may be used if both the EMResource and the Medical Communications System fail and an incident results in enough injuries to overwhelm the two or three nearest hospitals to the scene. The EMCC will contact St. Joseph Medical Center and request that the HEAR system be activated.

C. Once an alert is issued, The Primary Control Hospital contacts each hospital and collects treatment capability information, including the patient treatment capacity for three categories: Red, Yellow and Green.

D. All communications with Primary Control Hospital HEAR system or directly with all hospital emergency rooms should be made in plain language. The information should include a brief description of the incident (e.g., building collapse) and estimate of the number of casualties.

E. Based on the information about hospital capabilities collected by Primary Control Hospital, the Transportation Division/Group Supervisor determines the mode of transportation and coordinates patient disposition to the hospitals. The Transportation Officer should report back to on the number of patients being transported and to which hospitals.

F. The hospitals should call back to Primary Control Hospital to report on bed capacities.

G. The Primary Control Hospital will monitor the flow of patients to hospitals and notify the Transportation Division/Group Supervisor of hospitals that reach capacity. Those with the capability should monitor the HEAR system and communicate with the Transportation Division/Group Supervisor at the scene of the incident.

H. In the event that the Primary Control Hospital cannot be contacted the Alternate Control Hospital will then be designated as the Primary Control Hospital. In the event that neither of the control hospitals can be contacted, agencies in Kansas should contact the Johnson County Emergency Communications Center (913-432-1717) and agencies in Missouri should contact KCFD Communications (816-924-0600) to coordinate patient transportation and treatment.

Hospital Control Centers	
Primary Control Hospital	Contact Information
Alternate Control Hospital	Contact Information

Use of Wireless Phones

A. Historically wireless phone systems have failed during disasters. Reliance upon these systems for public safety communications during periods of disaster is questionable. However, depending upon the scope and type of the incident, wireless or cellular phones may provide a backup communications system.

B. If the incident is one of longer duration, area wireless companies could be asked to provide wireless phones and priority access at the scene of the incident. Satellite phones may be available through Emergency Management.

Interoperable Communications Systems

A. Several jurisdictions in the region have mobile communications vehicles and Communications Unit Leaders available for deployment to support on-site radio operations through a host of interoperable communications networks and tools. The capability of these resources is detailed in the Tactical Interoperability Communications (TIC) Plan. The TIC Plan is maintained by the Regional Interoperability Committee, a policy group representing public safety agencies throughout the region.

VII. MCI Equipment Caches

A. There are mass casualty equipment caches located throughout the metropolitan area. Each cache has a capability to treat approximately 50 to 100 patients. Some of the equipment is ALS capable.

B. Descriptions of the caches and how to request their response are included in **Appendix F**.

VIII. Pre-incident and Post-incident Activities

Review of Mass Casualty Incidents

A. MARCER can help facilitate an after action review if requested.

B. If no assistance is desired, MARCER will request information from appropriate agencies regarding the effectiveness of this plan.

Training and Exercises

A. MARCER will review the plan bi-annually, determine training needs and schedule appropriate training. The plan will be exercised annually in conjunction with other regional drills or exercises.

B. Local agencies are encouraged to continually train on patient triage, the use of triage tags, and patient tracking.

IX. Appendices

Appendix A: Regional EMS Resources

Appendix B: Regional Plans Index

Appendix C: ICS Position Descriptions

Appendix D: ICS Position Checklists

Appendix E: Patient Tracking with Scan ID Triage Tag

Appendix F: Regional Equipment Caches

Appendix A – Regional EMS Resources

AGENCY	NUMBER OF AMBULANCES		
		AVERAGE NUMBER IN SERVICE 24 HOURS A DAY	ADDITIONAL AMBULANCES IN SERVICE WITHIN ONE HOUR OF A CALL-BACK
CASS COUNTY	24 HR. PHONE		
Belton Fire Department	816-331-1500	2	1
Central Cass Fire Protection District	816-380-5200	1	1
Harrisonville EMS	816-380-8940	2	2
Pleasant Hill EMS	816-540-9109	1	1
South Metro Fire Protection District	816-331-0530	2	1
West Peculiar Fire Department	816-969-7407	1	1
CLAY AND PLATTE COUNTIES	24 HR. PHONE		
Claycomo Fire Department	816-452-4614	1	1
Excelsior Springs Fire Department	816-630-3000	2	1
Gladstone Public Safety Department	816-436-3550	2	2
Holt Community Fire Protection District	816-320-3612	1	1
Kearney Fire & Rescue	816-628-4122	2	0
Liberty Fire Department	816-439-4701	3	1
North Kansas City Fire Department	816-274-6032	2	0
Northland Regional Ambulance District	816-858-4450	3	2
CLINTON / DEKALB COUNTIES	24 HR. PHONE		
Cameron Fire Department	816-632-2345	2	1
DOUGLAS COUNTY	24 HR. PHONE		
Lawrence Douglas County Fire and Medical	785-830-7000	6	4
JACKSON COUNTY	24 HR. PHONE		
American Medical Response - Independence	816-461-3699	7 day / 4 night	3
Central Jackson County Fire Protection District	816-274-2121 816-923-7453	3	2
Ft. Osage Fire Protection District	816-969-7407 816-719-5204 Cell	2	1
Grandview Fire Department	816-316-4902	2	1
John Knox Village EMS	816-524-8400 or 816-246-4343 x2262	1	2
Lake Lotawanna	816-578-4211	1	0
Lee's Summit Fire Department	816-969-7407	5	1
Lone Jack Fire Protection District	816-697-2018	1	0
KCFD (Numbers include Jackson, Clay and Platte Counties)	816-923-3456 or 816-924-0600 x5	30	20
Prairie Township Fire Protection District	816-525-4200	1	1
Raytown EMS	816-737-6030	2	1
Sni Valley Fire Protection District	816-969-7407	2	0

AGENCY	NUMBER OF AMBULANCES	AVERAGE NUMBER IN SERVICE 24 HOURS A DAY	ADDITIONAL AMBULANCES IN SERVICE WITHIN ONE HOUR OF A CALL-BACK
JOHNSON COUNTY, KS	24 HR. PHONE		
Johnson County Fire District #2	913-432-2121	2	0
Lenexa Fire Department	913-432-2121	1	0
Johnson County Med Act (serves all cities located in Johnson County)	913-432-2121	16	7
LEAVENWORTH COUNTY	24 HR. PHONE		
Leavenworth County EMS	913-682-5724	4	2
RAY COUNTY	24 HR. PHONE		
Ray County EMS	816-470-3030	2	2
WYANDOTTE COUNTY	24 HR. PHONE		
American Medical Response – Wyandotte/ Johnson Counties	816-461-3699	3	2
Bonner Springs EMS	913-596-3050 913-422-7744	1	1
KCK Fire/EMS	913-596-3050	9	3
Edwardsville, KS EMS	913-422-5460	1	1
MIAMI COUNTY	24 HR. PHONE		
Miami County EMS	913-827-2602	3	1

AIR EMS PROVIDERS IN METRO KANSAS CITY	24 HR. PHONE	NUMBER OF HELICOPTERS
Life Net of the Heartland – St. Joseph	1-800-981-3062	1
Life Flight Eagle	1-800-422-4030	4
Life Star Air Ambulance - Lawrence	1-800-666-9111	1
GROUND & AIR EMS PROVIDERS OUTSIDE METRO KANSAS CITY		AVERAGE RESPONSE TIME TO METRO AREA
GROUND AGENCY	24 HR. PHONE	
Topeka – AMR	785-232-2222	1 hour
Wichita – Emergency Communications Admin	316-383-7077	4 hours
Columbia – Joint Communications	573-442-6131	2 hours
Springfield – Mercy EMS	417-820-3003	3 hours
Springfield – Cox Ambulance Service	417-269-3000	3 hours
St. Joseph – Buchannan County EMS	816-271-6558	1 hour
Sedalia – (PCAD) Pettis County Ambulance Dist.	660-829-0777	1.5 hours

AIR AGENCY		
KS / MO National Guard and Reserves (may not be available due to world events)	Activate through local EOC	12-14 hours activation time required, if available
Sedalia – Air Evac	800-247-3822	1 hour
Springfield – Mercy Life Line Air Med (Bolivar)	800-433-5433	1.25 hours
Springfield – Cox Air Care	800-333-5269	1.25 hours
Columbia – Staff of Life (LaMonte Base)	800-325-5400	.75 hour

REGIONAL HOSPITALS

MISSOURI		
Belton Regional Medical Center***	17065 So. 71 Hwy. Belton, MO 64012	816/348-1281
Cass Medical Center***	1800 East Mechanic Harrisonville, MO 64701	816/380-5888
Centerpoint Medical Center**	19600 E. 39th St. Independence, MO 64057	816/698-7000
Children's Mercy Hospital*	2401 Gillham Road Kansas City, MO 64108	816/234-3826
Excelsior Springs Medical Center	1700 Rainbow Blvd. Excelsior Springs, MO 64024	816/630-6081
Lee's Summit Medical Center***	2100 SE Blue Parkway Lee's Summit, MO 64081	816/282-5000
Liberty Hospital**	2525 Glen Hendren Drive Liberty, MO 64069	816-781-7200
North Kansas City Hospital**	2800 Clay Edwards Drive NKC, MO	816/691-2057
Research Brookside Campus	6601 Rockhill Rd. Kansas City, MO 64131	816/276-4546
Research Medical Center*	2316 E. Meyer Blvd. Kansas City, MO 64132	816/276-4155
St. Luke's East***	100 NE Saint Luke's Blvd. Lee's Summit, MO 64086	816/347-5000
St. Luke's Hospital Kansas City*	4401 Wornall Road Kansas City, MO 64171	816/932-6233
St. Luke's Northland Barry Rd.	5830 Barry Road Kansas City, MO 64154	816-891-6000
St. Luke's Northland Smithville	601 So. 169 Hwy Kansas City, MO 64089	816/532-3700
St. Joseph Medical Center	1000 Carondelet Drive Kansas City, MO 64114	816-942-4400
St. Mary's Medical Center	201 NW R.D. Mize Road Blue Springs, MO 64014	816/228-5900
Truman Medical Center*	2301 Holmes Kansas City, MO 64108	816/404-2661
Truman Lakewood Medical Center	7900 Lee's Summit Road Lee's Summit, MO	816/404-7000
KANSAS		
Children's Mercy Hospital South	5808 W. 110th St. Overland Park, KS 66211	913/696-8000
Cushing's Memorial Hospital	711 Marshall Leavenworth, KS 66408	913/684-1389
Lawrence Memorial Hospital	325 Maine St Lawrence, KS 66044	913/505-6237

KANSAS		
Miami County Medical Center	2100 Baptiste Dr. Paola, KS 66071	913/294-6655
Menorah Medical Center	5721 W. 119th Street Overland Park, KS 66209	913/498-7707
Overland Park Regional**	10500 Quivira Road Overland Park, KS 66215	913/541-5946
Providence Medical Center	8929 Parallel Kansas City, KS 66112	913-596-4000
Olathe Medical Center	20333 W. 151st Street Olathe, KS 66061	913/791-4200
Saint Luke's South Hospital	12300 Metcalf Ave. Overland Park, KS 66213	913/317-3477
Saint John Hospital	3500 So. Fourth St. Leavenworth, KS 66408	913/680-6000
Shawnee Mission Medical Center	9100 W. 74th St. Shawnee Mission, KS 64204	913/676-2208
University Of Kansas Hospital*	3901 Rainbow Blvd. Kansas City, KS 66160	913/588-0393

NON-REGIONAL HOSPITALS

Atchison Hospital	Atchison County	(913) 367-6624
Mosaic Life Care **	St. Joseph	(816) 271-6000 (ER) 816-271-6122
Lafayette Regional Health Center	Lafayette and Ray Counties	(660) 259-6862
Western Missouri Medical Center	Warrensburg	(660) 747-8824

** Level I Trauma Center* *** Level II Trauma Center* **** Level III Trauma Center*

Appendix B – Regional Plans Index

The following is a list and brief description of the regional plans with relevance to the regional MCI Plan.

Community Plan for Ambulance Diversion for the Greater Kansas City Metropolitan Area

Describes the ambulance diversion policies used throughout the metropolitan area. In addition to establishing diversion protocols, the plan describes a system of catchments for area hospitals. This system of catchments helps to ensure that if a hospital is closed to ambulances and/or trauma patients that patients may be quickly routed to another nearby hospital in the affected hospital's catchment area.
http://www.marc.org/emergency/marcerambulancediversion.htm

Kansas City Metropolitan Area National Disaster Medical System (NDMS) Plan

Describes the activities of the Kansas City Veterans Administration Medical Center (VAMC), which will serve as the Federal Coordinating Center (FCC) during events requiring activation of the NDMS. FCC responsibilities include coordinating the receipt and distribution of patients using policies and procedures developed in partnership with local, state and regional emergency response agencies and organizations providing support for NDMS operations.

Regional Public Health Emergency Plan Missouri Region A

Identifies and categorizes current public health resources in Missouri Region A, which is comprised of thirteen (13) counties in the northwest region of the state. This plan discusses coordination between local public health departments, emergency response agencies, emergency management and hospitals in the region. This plan contains a resource list of public health and medical capabilities by county.

Missouri Bioterrorism Region A Hospital Plan

Discusses the emergency operations of the hospitals and healthcare systems in thirteen (13) Missouri counties in the northwest region of the state. The plan addresses hospital capabilities and emergency procedures for the augmentation of healthcare facilities in the event of an infectious disease incident. It outlines regional medical response to an event and efforts to reduce the transmission of infectious agents.

Kansas Regional Hospital Plan – Northeast Kansas Region

Describes hospital operations in thirty-four (34) northeast Kansas counties. The plan addresses coordination between hospitals and the establishment of a regional hospital command. It discusses hospital resources and capabilities, and the coordination and sharing of hospitals resources in the Northeast Kansas Region.

Mid-America Local Emergency Planning Committee (LEPC) Plan

Provides an administrative framework for hazardous materials planning and response in the Missouri counties served by the Mid-America Local Emergency Planning Committee (LEPC). The plan is not an operational document, but rather a plan to assist emergency response agencies, local governments and the private sector in planning for hazardous materials emergencies. This plan is designed to meet the requirements of SARA Title III and the Missouri Emergency Response Commission. It includes a hazard assessment for the area and outlines hazardous materials capabilities to address the identified hazards.
Document contained in Homeland Security Information Network (HSIN)

Regional Coordination Guide

This plan ensures coordination and communication among the many jurisdictions in the region that will be critical during a mass casualty event. The Regional Coordination Guide describes how regional coordination will occur during emergency events. This guide includes information on the regional coordination of resources, public information and other emergency activities.
Document contained in Homeland Security Information Network (HSIN)

Local Plans

In addition to the regional plans described above, each county in Kansas and political subdivision in Missouri (counties and cities) maintain Emergency Operations Plans (EOPs), which lay the foundation for all emergency operations. Each county in the region, as well as several of the larger cities, also maintain local Public Health Bioterrorism Plans describing the emergency activities of the Public Health Departments and local emergency response agencies in the event of an infectious disease outbreak.

**** Due to the sensitive information contained within some documents, they are only available through the Homeland Security Information Network (HSIN). For access to this system, please contact the Mid-America Regional Council Emergency Services Department.***

Appendix C – Incident Command System Positions Descriptions

Incident Commander
Responsible for overall incident operations. The Incident Commander will designate the Medical Branch Director as determined by local protocol.

Medical Branch Director
Responsible for overall EMS operations at an incident, for appointing all other EMS team members and forwarding all EMS requests to the Incident Commander.

Liaison Officer
Responsible for coordinating with other appropriate agencies as needed, including other local agencies, federal, state or private sector agencies. These agencies may or may not be located at the command post.

Public Information Officer
Responsible for formulating and disseminating factual and timely information about the incident to the news media and other appropriate agencies.

Safety Officer
Responsible for monitoring emergency operations to ensure the safety of all personnel.

Planning Section Chief
Responsible for understanding the current situation and predicting the probable course of the incident. Develops the incident action plan.

Logistics Section Chief
Responsible for managing those units that provide personnel, ambulances, equipment, facilities, and personal needs in support of the incident activities.

Division/Group Supervisor
Responsible for a specific geographic area or specific function other than those listed (e.g., Haz-Mat Group Supervisor, Search Division Supervisor, etc.).

Triage Division/Group Supervisor
Responsible for the management of victims where they are found at the incident site, and for triaging and moving victims to the treatment or transport area.

Treatment Division/Group Supervisor
Responsible for sorting patients at the treatment area to establish priorities for treatment and transport, and for directing coordination with medical professionals assigned to treatment. The treatment area should be led by an individual with ALS certification.

Medical Transportation Division/Group Supervisor
Responsible for arranging appropriate transport vehicles (ambulances, helicopters, buses, vans, etc.) for those patients selected for transport.

Appendix D – Mass Casualty Incident Checklists

MEDICAL BRANCH DIRECTOR

- ☐ Assume assignment of Medical Branch Director from Incident Commander
- ☐ Identify yourself as Medical by wearing vest
- ☐ Perform a medical size-up and relay information to Command
  - ☐ Assess need for decontamination of patients prior to treatment or transport
- ☐ Develop an initial strategy for the medical aspects of the incident
- ☐ Contact appropriate EMCC and request the issuance of an MCI Alert. Provide the following information:
  - ☐ Type of incident and MCI level
  - ☐ Location of incident
  - ☐ Estimated number of patients
- ☐ Establish an ambulance staging area and notify Command
- ☐ Order additional medical resources needed through Command to include:
  - ☐ ALS Units/BLS Units
  - ☐ Mass Casualty Unit
  - ☐ Buses
  - ☐ Helicopters
  - ☐ Assistant to track resources being dispatched to the scene
- ☐ Appoint a Triage Supervisor, if required
- ☐ Appoint a Treatment Supervisor, if required
- ☐ Appoint a Transport Supervisor if required
- ☐ Track patients
- ☐ Communicate regular updates to Command on medical branch operations
- ☐ Communicate back to the appropriate EMCC with ongoing information on the status of the incident

TRIAGE Division/Group Supervisor

- ☐ Assume position of Triage Division/Group Supervisor and identify yourself by wearing vest
- ☐ Observe scene for hazards and take necessary precautions
- ☐ Confer with Safety Officer
- ☐ Determine the location, number and condition of patients involved in the incident
- ☐ Advise Medical Branch Director of the approximate number and severity of injuries

DO NOT PROCEED UNTIL THE ABOVE TASKS ARE DONE

- ☐ Establish a strategy for triage with the Medical Branch Director, including
  - ☐ Triage patients where they are found, or
  - ☐ Move patients to a designated area for triage
- ☐ Identify patients requiring rapid transport and get them off the scene quickly if resources allow
- ☐ Assess need for decontamination of patients prior to treatment or transport
- ☐ Assign personnel to direct walking wounded to triage area
- ☐ Track patients
- ☐ Determine and order any additional resources through Medical Branch Director, including
  - ☐ Additional personnel
  - ☐ Additional equipment or supplies
- ☐ Assign and control all personnel in the triage group to include
  - ☐ Establish triage teams and define operating zones
  - ☐ Assure that sufficient quantities of triage tags are available
- ☐ Provide regular progress reports to Medical Branch Director
- ☐ Advise "All Clear" to Medical Branch Director when all patients have been triaged and moved to the treatment group

TREATMENT Division/ Group Supervisor

- ☐ Assume position of Treatment Division/Group Supervisor upon assignment by Medical Branch Director and identify yourself by wearing vest
- ☐ Determine the location for the treatment area and notify the Medical Branch Director
- ☐ Determine and order any additional resources through Medical Branch Director, including
  - ☐ Additional personnel, including the need for on-site physician
  - ☐ Mass casualty unit(s)
- ☐ Construct a formal treatment area to include
  - ☐ Identifiable entrance and exit points by using stakes and barrier tape
  - ☐ Separate red and yellow triaged patients within the treatment area. Do not delay transport of red triaged patients, if resources allow.
  - ☐ Develop a pool of medical supplies within the treatment area from mass casualty unit and non-transporting units
  - ☐ Designate an area for green triaged patients to be collected and treated outside the formal treatment area
- ☐ Track patients
- ☐ Locate yourself at the entrance point and perform re-triage as needed on patients arriving from the triage group
- ☐ Perform triage on patients arriving into the treatment area without triage tags
- ☐ Assign and control all personnel in the sector to ensure appropriate treatment for all patients
- ☐ Move patients through the exit point into the transportation group in order of severity
- ☐ Provide regular progress reports to Medical Branch Director
- ☐ Advise “All Clear” to Medical Branch Director when all patients have been treated and moved to the transport group

MEDICAL TRANSPORTATION Division/Group Supervisor

- ☐ Assume position of Transportation Division/Group Supervisor upon assignment by Medical Branch Director and identify yourself by wearing vest
- ☐ Determine the location for the staging of the ambulances
  - ☐ Access and Egress routes
  - ☐ Patient Loading Area
- ☐ Determine and order any additional resources through Medical Branch Director, including
  - ☐ Personnel
  - ☐ Ambulances
  - ☐ Helicopters
  - ☐ Buses
- ☐ Communicate with the appropriate EMCC to determine hospital availability and capacities
- ☐ Appoint a Medical Staging Officer to control ambulance flow
- ☐ Track patients – maintain accurate records of all patient transports on tracking boards or sheets
- ☐ Coordinate patient removal to loading zones in order of severity to include moving patients to helicopter landing zone for transport to distant hospitals
- ☐ Provide regular progress reports to Medical Branch Director
- ☐ Advise “All Clear” to Medical Branch Director when all patients have been transported

Appendix E – Patient Tracking

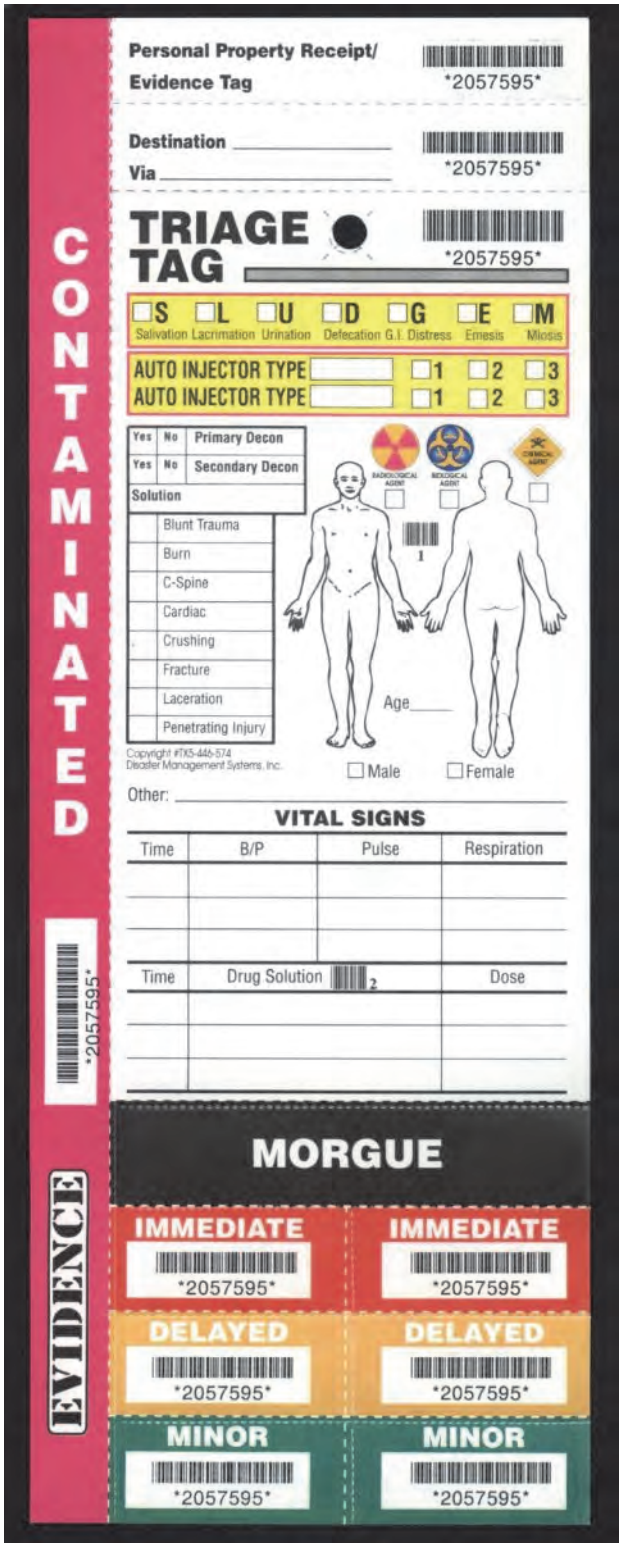
A. Each agency has the responsibility to maintain accountability of patient movement through a manual process as identified by their respective organizational protocols and/or guidelines. The use of patient tracking boards or sheets is strongly recommended.

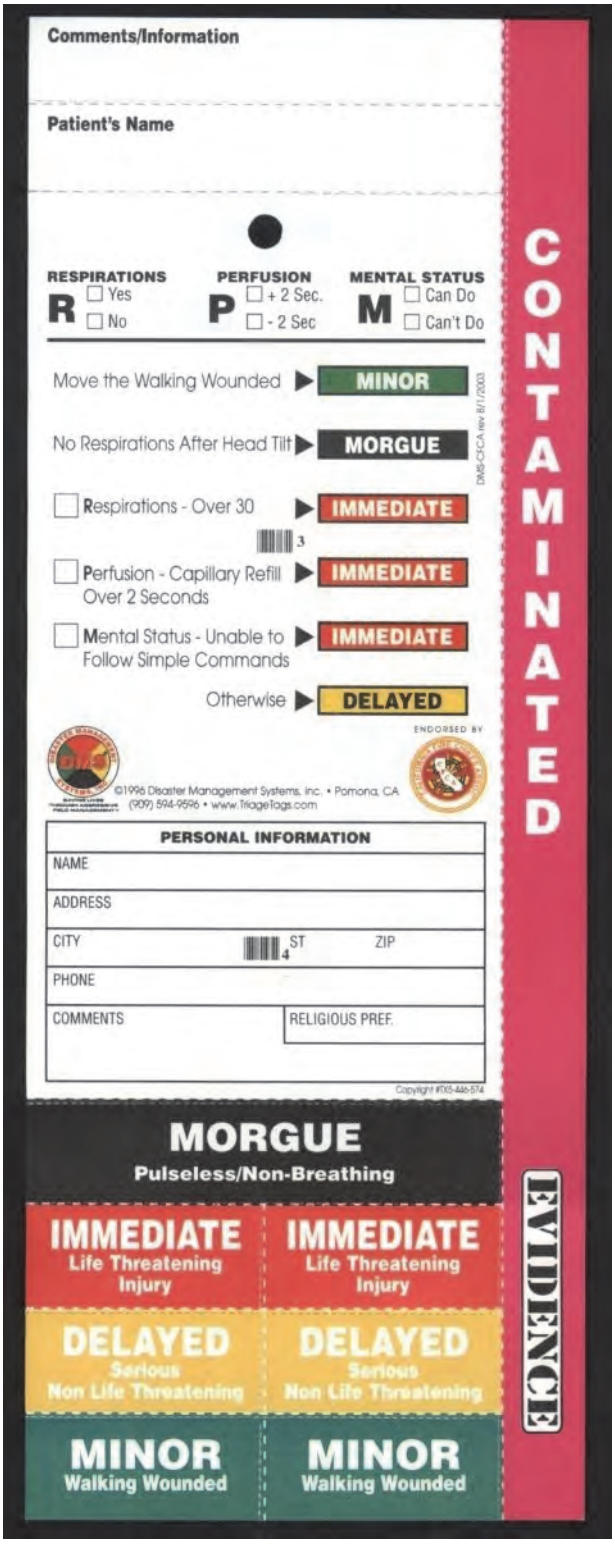
B. Patient Tracking should be pre-planned for any known mass gathering.

C. When an incident has more than 10 patients, the use of triage tags should be implemented to aid in tracking.

D. The triage tags should be filled out with as much information about the patient as personnel are able to ascertain and complete. A portion of the tag should be retained along with a record including to which hospital the patient was transported. The Transportation Division/Group Supervisor will make the information available to American Red Cross representatives or others responsible for notifying family members or determining the location of victims, as appropriate.

E. Patients are issued triage tags that provide a color coded status (Red, Yellow, Green and Black) as part of the on-scene triage process. The tags allow triage personnel to record specific patient information that becomes part of the patient record. The triage tag is illustrated on the following page.


CONTAMINATED
Personal Property Receipt/
Evidence Tag
2057595
Destination
Via
2057595
TRIAGE TAG
2057595
S L U D G E M
Salivation Lacrimation Urination Defecation G.I. Distress Emesis Miosis
AUTO INJECTOR TYPE 1 2 3
AUTO INJECTOR TYPE 1 2 3
Yes No Primary Decon
Yes No Secondary Decon
Solution
Blunt Trauma
Burn
C-Spine
Cardiac
Crushing
Fracture
Laceration
Penetrating Injury
Age
Male
Female
Other:
VITAL SIGNS
Time
B/P
Pulse
Respiration
Time
Drug Solution
Dose
MORGUE
IMMEDIATE
DELAYED
MINOR
EVIDENCE


CONTAMINATED
Comments/Information
Patient's Name
RESPIRATIONS
R Yes No
PERFUSION
P + 2 Sec. - 2 Sec
MENTAL STATUS
M Can Do Can't Do
Move the Walking Wounded
MINOR
No Respirations After Head Tilt
MORGUE
Respirations - Over 30
IMMEDIATE
Perfusion - Capillary Refill Over 2 Seconds
IMMEDIATE
Mental Status - Unable to Follow Simple Commands
IMMEDIATE
Otherwise
DELAYED
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(909) 594-9596 • www.TriageTags.com
PERSONAL INFORMATION
NAME
ADDRESS
CITY
ST
ZIP
PHONE
COMMENTS
RELIGIOUS PREF.
MORGUE
Pulseless/Non-Breathing
IMMEDIATE
Life Threatening Injury
DELAYED
Serious Non Life Threatening
MINOR
Walking Wounded
EVIDENCE

Appendix F – Mass Casualty Incident Caches of Supplies

There are caches of equipment intended for MCI use located throughout the metropolitan area. Each cache has a capability to treat approximately 50 to 100 patients. Some of the equipment is ALS capable. Caches include the following:

Western Missouri Fire Chiefs Association MCI Trailer
One trailer available: Located at Central Jackson County Fire Protection District Station #4
Contact: Fire Mutual Aid to Central Jackson County Fire Protection District or call (816) 220-4005

- Capacity to treat up to 50-100 patients
- Carries ALS (IV and intubation equipment) and oxygen

North Kansas City Fire Department
One trailer available: Located at North Kansas City Fire Department Station #2
Contact: Call (816) 274-6010 or (816) 274-6013

- Capacity to treat up to 50 patients
- BLS equipped

Kansas City, Kansas Fire Department
One trailer available: Located at Kansas City, Kansas Fire Department Station #6
Contact: Call (913) 596-3050

- Capacity to treat up to 50 patients
- BLS equipped

Johnson County MED-ACT
Two trailers available: One in Mission and one in Olathe
Contact: Johnson County Emergency Communications Center at (913) 432-2121

- Each trailer has a capacity to treat up to 50-100 patients
- ALS and BLS equipped
- Multiple oxygen delivery devices

Kansas City International Airport
Note: This truck cannot leave airport grounds

- Capacity to treat up to 100 patients

KCFD
One Trailer at the Eastwood Facility
Contact: Call (816) 924-0600

- Capacity to treat up to 50-100 patients
- ALS equipped

Northland Regional Ambulance District
One Trailer at NRAD Headquarters
Contact: Call (816) 858-4450

- Capacity to treat up to 50-100 patients
- ALS equipped

Belton Fire Department
One Trailer at Station #1
Contact: Call (816) 331-1500

- Capacity to treat up to 50-100 patients
- ALS equipped

Lawrence/Douglas County Fire & Medical
One Trailer at LDCFM Station #2
Contact: Call (785) 830-7000

There is no cost for the use of the equipment, other than the replacement of expended supplies. To request the cache be deployed to an incident, contact the communications center or listed contact for each jurisdiction.

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ESF 8 ATTACHMENT E

ATTACHMENT E:

Community Plan for Ambulance Diversion for the Greater Kansas City Metropolitan Area

ATTACHMENT E. COMMUNITY PLAN FOR AMBULANCE DIVERSION FOR THE GREATER KANSAS CITY METROPOLITAN AREA

Organization and Management for Hospitals and EMS Agencies
For The Greater Kansas City Metropolitan Area

A Community Plan for Diversion

Approval Date: March 27, 2002
Implementation Date: May 1, 2002
Revised: January 27, 2004
Revised: February 14, 2005
Revised: March 29, 2005
Revised: June 1, 2005
Revised: March 13, 2007
Revised: March 30, 2007
Revised: February 13, 2008
Revised: May 21, 2009
Revised: November 16, 2009
Revised: March 24, 2011
Revised: March 13, 2013

I. Background

The Diversion Work Group of the Health Alliance of MidAmerica and Mid-America Regional Council Emergency Rescue (MARCER) Committee have adopted ambulance diversion guidelines for the greater Kansas City metropolitan area.

Each metropolitan EMS agency has a set of protocols and policies approved by their medical director and/or medical control board. These include ambulance routing protocols. The specific protocols utilize the "hospital diversion status" information supplied by a region wide, real-time tracking system and help the paramedic on the street make routing decisions with or without radio contact with a medical control physician. The ambulance routing protocols of the largest metropolitan EMS systems (Kansas City, Missouri EMS System with its Emergency Physicians Advisory Board, the Kansas City, Kansas EMS System with its Wyandotte County Medical Control Board and the Johnson County EMS System with its Johnson County Medical Control Board), while similar, are not the same. In addition, there are multiple smaller EMS agencies with their own protocols.

II. EMResource

MARCER, with the endorsement and cooperation of multiple agencies, organizations and hospitals, has implemented the EMResource across the Kansas City metropolitan region. "The EMResource is a Web-based program providing real-time information on hospital emergency department status, hospital patient capacity, availability of staffed beds and available specialized treatment capabilities. The EMResource is used to coordinate "routine" and emergency medical operations (e.g. mass casualty incidents or MCIs) throughout the region."

The EMResource is an information system. "With EMResource, the definition of hospital status is standardized across the entire Kansas City metropolitan area. Emergency medical providers and/or emergency medical systems should continue to follow their local policies and procedures regarding the determination of hospital destinations. It is up to each EMS agency to determine what they will do with the status information on and further communicate their operational plans to their respective hospitals of interest. EMResource provides standardized information to facilitate patient routing decisions."

III. Policy

A. Patient care and safety should be the central consideration in all diversion decisions.

B. The decision to divert should be based on the immediate capabilities and capacities of the emergency department and institution to care for patients. (An exception is trauma diversion, in which availability of an operating room or appropriate surgeon may limit the ability to function as a trauma center).

C. Patients who are in cardiac arrest will be taken to the closest appropriate hospital, unless the hospital is "out of service." Patients who are "unstable" may still be taken to the closest appropriate hospital, unless it is "out of service" or on "trauma diversion" (for "unstable" trauma patients only).

D. The patient shall be informed when the hospital of his or her choice is on diversion and that, in such cases, resources normally utilized for treatment may not be available. Based upon local EMS agency policies, if a patient demands transport to a hospital that is on diversion, and if the patient is refusing transport because their hospital of choice is on diversion status, then the medic may take the patient to the hospital of the patient's choice. EMS agencies shall follow their local policies regarding appropriate documentation of such patient requests.

E. Level I or Level II trauma centers may close to ambulances carrying patients who meet EMS trauma routing criteria.

F. Level I or Level II trauma centers may remain open ONLY for EMS trauma routing, while the ED is closed to all other ambulance traffic.

G. STEMI and/or stroke centers may close to ambulances that have patients that meet TCD routing criteria for STEMI and/or stroke.

H. STEMI and/or stroke centers may remain open ONLY for patients meeting TCD routing criteria, while the ED is closed to other ambulance traffic.

I. No facility can divert patients on the basis of ability to pay.

J. Hospitals going on a divert status must do so prior to being notified of an ambulance's impending arrival (i.e. there should be no "diversions in route"). During multi-casualty incident (MCI) the EMS agency may distribute patients to multiple facilities in order to optimize utilization of resources. This should not be interpreted as a "diversion en route".

K. Each hospital should develop its own internal policy regarding ambulance diversion.

L. Diversion notifications should be made to all EMS providers, hospitals and EMCCs (EMResource Coordination Centers) through the EMResource. (If there is a local problem with the EMResource, the appropriate EMCC can be contacted by phone or FAX and enter the notification into the EMResource).

M. If all hospitals within a predefined catchment area are closed, then all are "forced open" and the patient will be taken to the closest appropriate hospital within the catchment area (with the exception of hospitals that are out of service).

1. If all hospitals in a catchment area are "closed to ambulances" and therefore all are "forced open," then ambulances transporting patients to the now "forced open" hospitals will be distributed in a fashion so to equalize as much as possible the number of patients going to those now "forced open" hospitals.

2. If all hospitals in a catchment area are "closed to ambulances" and therefore all are "forced open," ambulances stationed in and/or normally transporting to hospitals in other catchment areas, will make every effort (within the bounds of this policy and their own EMResource policy) to not transport patients to hospitals that are "forced open" only because all hospitals in their catchment area were closed.

3. If a trauma, STEMI or stroke center is in a catchment area in which all hospitals are now "forced open" only because all have "closed," it does not automatically mean that the trauma, STEMI or stroke center is open for trauma, STEMI or stroke patients. (There are specific criteria that must be met in order to be designated a trauma, STEMI or stroke center.) That decision is made by the involved trauma, STEMI or stroke center.

N. In the event hospital EDs across the region become saturated as defined by any time one half of the metropolitan area catchment hospitals are "Closed to Ambulances" or during a large scale mass casualty incident occurrence, the EMResource Administrator has the authority to temporarily suspend the "Closed to Ambulance" option of the community plan. The suspension of "Closed to Ambulance" would be for an eight (8) hour period and then re-evaluated. The temporary suspension of the community plan does not affect other EMResource categories related to trauma or out of service conditions.

O. The Kansas City community plan for ambulance diversion makes a clear distinction between emergency transport of patients who require emergency care and individual hospital policies regarding the transportation and receiving of patients for direct admission to the hospital. Specific examples include patients who require hospital admission from a primary care physician's office, recently discharged surgical patients, or patient transport from a nursing home to a hospital for non-life threatening conditions. Hospitals whose emergency departments become overwhelmed and are "closed to ambulances" may continue to accept such patients by ambulance for direct admission to the hospital. Since direct admission policy and procedures may vary from one hospital to another, EMS agencies and hospitals are encouraged to work closely together to coordinate direct admissions to avoid additional congestion in the ED.

P. MARCER and the Health Alliance of MidAmerica have jointly developed a process to track hospital diversions, to monitor trends, to monitor compliance with protocols and to produce appropriate reports for routine review.

IV. Definitions

Diversion – The rerouting of an ambulance(s) from the intended receiving facility to an alternate receiving facility due to a temporary lack of critical resources in the intended receiving facility.

Diversion Categories:

OPEN – The hospital ED is open to all ambulance traffic.
Note: All hospitals must update their "OPEN" status at least two times a day at 0800 and 2000.

FORCED OPEN – The hospital ED has been changed to a Forced Open status due to all hospitals within their catchment area being closed to ambulances.
Note: Hospitals that are "FORCED OPEN" must remain open for at least one (1) hour before changing their status back to "CLOSED TO AMBULANCES."

CLOSED TO AMBULANCES – The emergency department is functioning but cannot accept ambulance patients due to a temporary resource limitation.
Note: The EMSystem® must be updated each hour (at one hour intervals) when on "CLOSED TO AMBULANCES" status.

OUT OF SERVICE – The emergency department has suffered structural damage, loss of power, an exposure threat or other conditions that precludes the admission and care of any new patients.
Note: The EMResource must be updated each hour (at one hour intervals) when on "OUT OF SERVICE" status.

CLOSED TO TRAUMA – Level I or Level II trauma centers may close to ambulances carrying patients who meet EMS trauma routing criteria.
Note: The EMResource must be updated each hour (at one hour intervals) when on "CLOSED TO TRAUMA" status.

OPEN TO TRAUMA – Level I or Level II trauma center is open ONLY for EMS trauma routing while the ED is closed to all other ambulance traffic.

CLOSED TO STEMI – STEMI centers may close to ambulances that have patients that meet STEMI ROUTING CRITERIA.
Note: The EMResource must be updated each hour (at one hour intervals) when on "CLOSED TO STEMI" status.

OPEN TO STEMI – STEMI center is open ONLY to ambulances that have patients that meet STEMI routing criteria while the ED is closed to all other ambulance traffic.

CLOSED TO STROKE – Stroke centers may close to ambulances that have patients that meet stroke routing criteria.
Note: The EMResource must be updated each hour (at one hour intervals) when on "CLOSED TO STROKE" status.

OPEN TO STROKE – Stroke center is open ONLY to ambulances that have patients that meet stroke routing criteria while the ED is closed to all other ambulance traffic.

Hub Hospital – The hub hospital is defined as the preferred location for emergency care. The preferred hospital location factors may include:

- Transport for trauma care
- Transport for specialty care
- Patient choice
- Direct admissions
- Proximity
- Children's hospital

Catchment Area – Catchment areas are comprised of one hub hospital and three or more hospitals that are related by multiple factors such as ground time, capabilities and traffic flow for diversion purposes. A hospital may be part of more than one group. These catchment hospitals are to be defined and reviewed at least annually by MARCER. Attachment A contains a list of participating hospitals and their respective catchment designations.

Unstable –

- Unable to establish or maintain an airway
- Unable to ventilate
- Unremitting shock
- As otherwise defined in appropriate EMS agency protocols, (including
- As determined with medical control contact)

V. Procedures

A. The decision to initiate or terminate a diversion status rests with the individual hospital according to their written policies.

B. Criteria to determine the necessity of implementing the hospital diversion plan include: ED bed saturation; number of patients in the ED waiting area, as well as patient waiting times; number of ambulance patients waiting or en route; acuity of patients waiting to be admitted; and ED staffing capabilities. Forms for tracking this information are available on the EMResource or at the MARCER web site.

C. The diversion is initiated or terminated using the EMResource according to the EMResource Protocols and Policies.

D. For participating Missouri hospitals in the Kansas City region, the EMResource will automatically notify the Missouri Department of Health and Senior Services (DHSS) upon commencement of diversion status via an electronic mail message. In the event the EMResource is not operational at the commencement time of diversion, participating Missouri hospitals will send DHSS a fax notification or, by other electronic means, report the commencement of diversion.

E. The appropriate EMCC and/or EMS dispatch center ensures that ambulance crews in the field are informed of hospital diversion status on a "real-time" basis through their own written policies, protocols or standard operating procedures.

F. The ambulance crews in the field use all appropriate information to make the destination determination. In some systems this may also include on-line contact with a medical control physician.

G. If all but one hospital in a catchment area is "closed to ambulances," the appropriate EMCC will contact the hospitals involved in that catchment area via the EMResource, inform them of that fact and request an update of their diversion status.

H. If all hospitals in a catchment area are "closed to ambulances," the appropriate EMCC will contact the hospitals in that catchment area via the EMResource, inform them of that fact and request an update of their diversion status. If, within 10 minutes of this contact, none of the hospitals in the

catchment area have changed their status to either "open" or "trauma diversion" then the EMCC will change all of the hospitals in the catchment area to "forced open."

I. Within eight (8) hours of termination of the diversion, participating Missouri hospitals in the Kansas City region will report the following information to the Missouri DHSS via the EMResource or by other electronic means:

1. Diversion start time
2. Name of individual who made the decision to implement the diversion status
3. Reason for the diversion status
4. Time the diversion was terminated
5. Name of the individual who made the decision to terminate the diversion status

VI. References

- National Association of Emergency Medical Services Physicians Position Paper: Ambulance Diversion; approved by the NAEMSP Board of Directors, July 26, 1995
- EMResource Protocols and Policies; MARCER, June 2000
- American College of Emergency Physicians Policy Education Resource Paper: Guidelines for Ambulance Diversion; AEM 36:4 376-377
- East Metro Ambulance Diversion Policy; East Metro Hospital, St. Paul, MN, June 30, 2000
- Emergency Department Diversion Guidelines of the St. Louis Emergency Physicians Association; St. Louis, MO August 2000

Appendix A

Kansas City Metropolitan Region
Regional Catchment Areas for Hospital Diversion

Hub Hospital	Catchment Area
Centerpoint Medical Center	Centerpoint Medical Center Lee's Summit Medical Center Saint Luke's East Hospital St. Mary's Medical Center Truman Medical Center, Lakewood
Lee's Summit Medical Center	Centerpoint Medical Center Lee's Summit Medical Center Research Medical Center* Saint Luke's East Hospital Truman Medical Center, Lakewood
Liberty Hospital	Liberty Hospital North Kansas City Hospital*

	Saint Luke's North Hospital – Barry Road*
Menorah Medical Center	Menorah Medical Center Olathe Medical Center Overland Park Regional Medical Center St. Joseph Medical Center Saint Luke's South Hospital
North Kansas City Hospital	Liberty Hospital* North Kansas City Hospital Saint Luke's North Hospital – Barry Road* Truman Medical Center, Hospital Hill
Olathe Medical Center	Menorah Medical Center* Olathe Medical Center Overland Park Regional Medical Center St. Joseph Medical Center
Overland Park Regional Medical Center	Menorah Medical Center Olathe Medical Center Overland Park Regional Medical Center St. Joseph Medical Center Saint Luke's South Hospital Shawnee Mission Medical Center
Providence Medical Center	Overland Park Regional Medical Center* Providence Medical Center Shawnee Mission Medical Center* University of Kansas Hospital*
Research Medical Center	Research Medical Center St. Joseph Medical Center Saint Luke's Hospital of Kansas City Truman Medical Center, Hospital Hill
St. Joseph Medical Center	Menorah Medical Center Olathe Medical Center Overland Park Regional Medical Center
Saint Luke's Hospital of Kansas City	Research Medical Center Saint Luke's Hospital of Kansas City Truman Medical Center, Hospital Hill University of Kansas Hospital
Saint Luke's East Hospital	Centerpoint Medical Center Lee's Summit Medical Center Saint Luke's East Hospital Truman Medical Center, Lakewood
Saint Luke's North Hospital – Barry Road	Liberty Hospital* North Kansas City Hospital* Saint Luke's North Hospital – Barry Road
Saint Luke's South Hospital	Menorah Medical Center Olathe Medical Center* Overland Park Regional Medical Center St. Joseph Medical Center

	Saint Luke's South Hospital
Shawnee Mission Medical Center	Overland Park Regional Medical Center Olathe Medical Center* Saint Luke's South Hospital* Shawnee Mission Medical Center University of Kansas Hospital
St. Mary's Medical Center	Centerpoint Medical Center Lee's Summit Medical Center* Saint Luke's East Hospital St. Mary's Medical Center Truman Medical Center Truman Medical Center, Lakewood
Truman Medical Center, Hospital Hill	North Kansas City Hospital Research Medical Center Saint Luke's Hospital of Kansas city Truman Medical Center, Hospital Hill University of Kansas Hospital
Truman Medical Center, Lakewood	Centerpoint Medical Center Lee's Summit Medical Center Saint Luke's East Hospital St. Mary's Medical Center Truman Medical Center, Lakewood
University of Kansas Hospital	Research Medical Center Saint Luke's Hospital of Kansas City Shawnee Mission Medical Center Truman Medical Center, Hospital Hill University of Kansas Hospital

- Children's Mercy Hospital – As the only pediatric hospital, it is not included in any catchment area.
- Children's Mercy South – Not included in any catchment area.
- Veteran's Administration Hospital – Not included in any catchment area.
- Bates County Memorial Hospital (Butler, Missouri), Cass Regional Medical Center (Harrisonville, Missouri), Cushing Memorial Hospital (Leavenworth, Kansas), Excelsior Springs Hospital (Excelsior Springs, Missouri), Lafayette Regional Health Center (Lexington, Missouri), Lawrence Memorial Hospital (Lawrence, Kansas), Belton Regional Medical Center (Belton, Missouri) and Saint John Hospital (Leavenworth, Kansas) – Not included in any catchment area due to the geographic distance to the metropolitan region.
- Research Medical Center Brookside Campus (formally Baptist Lutheran Medical Center) and Lee's Summit Medical Center – Summit Ridge Campus (former site for Lee's Summit Hospital) – not included in any catchment area due to limited inpatient capabilities.

*Indicates a greater than 15 minute drive

- Approved: 3/27/02
- Revised: 1/27/04
- Revised: 2/15/05
- Revised: 3/29/05 – Addition of Saint Luke's East – Lee's Summit Campus to catchment areas

- Revised: 6/1/05 – Addition of new Trauma Only status
- Revised: 3/13/07 – Addition of Centerpoint Medical Center to catchment areas and pending removal of Independence Regional Medical Center and Medical Center of Independence due to expected closure in late spring 2007. Removal of Baptist Lutheran Medical Center (now Research Medical Center Brookside Campus) due to limited inpatient capabilities.
- Revised: 3/30/07 – Addition of Olathe Medical Center to Menorah Medical Center catchment area
- Revised: 2/13/08 – Clarification of protocols and time frames for each EMResource status category, removal of Independence Regional Medical Center and Medical Center of Independence due to opening of Centerpoint Medical Center plus notation of ED at Lee's Summit Medical Center – Summit Ridge Campus.
- Revised: 5/21/09 – Add EMS trauma routing criteria language
- Revised: 11/16/09 – Add provision to temporarily suspended "Closed to Ambulance" during region saturation
- Revised: 3/24/11 – Add new STEMI and Stoke Center diversion categories; change all reference from EMSystem to EMResource (May 2, 2011, implementation date)
- Revised: 3/13/13 – Updated hub and catchment areas with hospital name change as well as the footnotes to include Children's Mercy South

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ATTACHMENT F:

MARCER Regional High Demand Plan

ATTACHMENT F. MARCER REGIONAL HIGH DEMAND PLAN

Version 4

I. Definitions

- Call Volume: the number of active emergency calls for the monitored services. Rationale for this trigger is to notify regional agencies when call volume is unusually high and adjustments in capacity may be advisable.
- Dashboard: the FirstWatch resource that MARCER agencies can use to monitor de-identified activity of the monitored services in order to stay abreast of regional EMS demand. The user-configurable dashboard contains speedometers for the four regional triggers.
- EMResource: a Web-based software product for inventory and resource management by Intermedix/EMSystems. In the Kansas City metropolitan area, EMResource is used to monitor hospital diversion status and facilitate hospital notification and polling in the event of a mass casualty incident.
- FirstWatch: a Web-based software product for syndromic surveillance, early event detection, situational awareness, and operational reporting by Stout Solutions, LLC. In the Kansas City metropolitan area, monitored services provide ambulance dispatch information to FirstWatch, which analyzes the data for patterns and spikes in specific types of calls.

- Hospital Status List: provides near real-time views of EMS units enroute and arrived at specific hospital locations from emergency calls. This web-based view refreshes automatically to provide current transport status by hospital. Information displayed for each hospital includes the number of EMS units enroute to and arrived at each facility, the average turnaround time and the maximum turnaround time. Hospitals are listed alphabetically.
- Mission Time: the average amount of time from dispatch to back in service. Rationale for this trigger is to notify regional agencies when the amount of time to complete an ambulance call is high, decreasing the capacity of EMS units to handle the call volume.
- Monitored Service: agencies that currently provide data to FirstWatch. These agencies constitute the majority of geographic coverage and call volume for the Kansas City metropolitan area. These agencies are American Medical Response, Johnson County Med-Act, the Kansas City Fire Department, and the Kansas City, Kansas Fire Department.
- Notification: a message sent via pager, email, and/or SMS message to pre-identified staff at each MARCER agency. Brief messages will indicate the nature of the notification. Further information may be available by logging onto the dashboard.
- Patient Offload Time: the average amount of time from arriving at the hospital until the ambulance is back in service or available for another call. Rationale for this trigger is to notify regional agencies when the amount of time to transfer care of the patient at the hospital is high, increasing the amount of time it takes to get an EMS unit back in service.
- Phases: common nomenclature that allows EMS agencies to describe their operational level to others. EMS agencies may choose to upgrade their Phase in anticipation of an event or in response to an event.
    - Phase 0: normal day-to-day operations.
    - Phase 1: the agency has made some temporary adjustments to account for a busy period of time. The adjustments will not alter their response to calls.
    - Phase 2: the agency has made major adjustments to address a crisis situation. The adjustments will alter their response to calls.
- Red Alert: this alert is reached when a trigger exceeds the average plus three times the standard deviation.
- Transport Volume: the number of active emergency calls currently transporting from the scene to the hospital. Rationale for this trigger is to notify regional agencies when a high number of patients are being transported. This may result in hospital closures, transports to more distant facilities, and longer turnaround times
- Trigger: pre-set parameter within FirstWatch that, when reached, causes an automatic notification to be sent to MARCER agency staff. Triggers currently configured are call volume, transport volume, hospital turnaround time, and mission time.
- WebEOC EMS: a WebEOC board providing a virtual EOC for EMS agencies to coordinate their activities.
- Yellow Alert: this alert is reached when a trigger exceeds the average plus two times the standard deviation.

II. Mission

The Mid America Regional Council Emergency Rescue (MARCER) Committee developed this Regional High Demand Plan (RHDP) to provide the best pre-hospital care to the greatest number of people during a critical situation. Critical situations include, but are not limited to:

- Weather-related, i.e. ice storm with widespread power outages, winter storm seriously impacting vehicular movement or tornado strike with significant damage/injuries across jurisdictions.

- Health-related, i.e. flu outbreak limiting pre-hospital and hospital resources.
- Federal or state emergency declarations, i.e. health, security, or weather-related.
- Civil or terrorist-related with significant illnesses/injuries, infrastructure disruption, and/or property destruction.
- Level IV mass casualty incident.
- Mass evacuation into or out of the region.

III. Revision Schedule

This plan will be reviewed bi-annually by MARCER and as part of any after action review.

IV. Authorities

MARCER as a regional collaboration of ambulance service providers developed this plan to enhance the region's capabilities to respond to a critical situation. The authority to implement this plan rests with the local governing body, the ambulance service provider and their medical director. These entities must review, adapt, and adopt the plan to fit their locale. Authority to initiate the plan in the face of a critical situation must be spelled out in the locally-adopted plan. Local agencies are strongly encouraged to coordinate their actions with neighboring communities.

V. Planning Assumptions

- Call volume will exceed available ambulance and first responder resources in the Kansas City metropolitan area.
- Mutual aid is not available as neighboring communities are facing the same critical situation.
- The RHDP is a planning document to be used by local agencies and medical directors to develop their local response(s) to critical situations.
- The modifications outlined herein are radical in nature and coordination between local agencies is vital during these critical situations.

VI. Ethical Principles

- Limitation of Individual Autonomy: the fair and just rationing of scarce resources requires public health decisions based on objective factors, rather than on the choice of individual leaders, providers or patients. All individuals should receive the highest level of care given the resources available at the time.
- Transparency: governments and institutions have an ethical obligation to plan allocation through a process that is transparent, open, and publically debated. Governmental honesty about the need to ration medical care justifies institutional and professional actions of withholding and withdrawing support from individual patients. These restrictive policies must be understood and supported by medical providers and the public, ideally with reassurances that institutions and providers will be acting in good faith and legally protected in their efforts.
- Justice/Fairness: the proposed triage process relies on the principle of maximum benefit to the population served. The triage process treats patients equally based on objective, physiologic criteria and when these criteria do not clearly favor a particular patient, "first come, first served" rules will apply.

- Assurance: in order to ensure "procedural justice," EMS triage processes will be regularly evaluated to ensure that the process has been followed fairly and consistently.

VII. Regional Alerts

The region utilizes FirstWatch to monitor the call volume of the four largest EMS agencies in the Kansas City metropolitan region. FirstWatch monitors data 24/7 from the respective computer aided dispatch systems and compares it to the historical average for that time period. FirstWatch monitors four parameters, the call volume, the transport volume, the patient offload time, and the overall mission time. When an individual agency reaches an alert level for their particular agency, FirstWatch delivers alerts through selected media (pager, SMS message, email) to that agency's designated users. When the region reaches an alert level for the four agencies combined, FirstWatch delivers alerts through selected media (pager, SMS message, email) to designated regional users. This includes individual EMS agencies, hospitals, emergency management, and public health departments throughout the region.

Receipt of a single regional alert should prompt consideration of the following actions on the part of local entities:

- Comparing the regional alert against local entity performance, i.e.is the local service also experiencing a higher call volume when the regional call volume trigger is activated?
- Checking EMResource for current hospital status.
- Checking other resources to identify a possible cause for the regional alert, i.e. the National Weather Service reporting winter weather moving into the area, media reporting a large incident with potential casualties, etc.
- Estimating how long the possible cause may affect the region and the local entity.
- Anticipating what, if any, effect the regional alert may have on the local entity.

Receipt of multiple regional alerts should prompt consideration of the items above as well as instituting components of the locally-adopted plan, if appropriate.

VIII. Notification

- The initiating event notification will normally be a regional trigger alert sent by FirstWatch to regional users.
- Regional users should follow the considerations in the previous section to educate themselves to the severity of the situation.
- If an EMS agency chooses to move from Phase 0 (normal day-to-day operations) to Phase 1 (temporary adjustments to account for a busy period of time. The adjustments will not alter their response to calls.), as a result of the previous step, they should have a notification procedure for both internal and external contacts.
- If an EMS agency judges the situation severe enough to move to Phase 2 (major adjustments to address a crisis situation. The adjustments will alter their response to calls.), they should consider initiating a conference call with the other regional EMS agencies to discuss the situation. The healthcare notification system, Citywatch, can be used to rapidly contact designated staff at other EMS agencies to advise of a Phase change or set up the call. MARC staff maintains a notification group for the purpose of regional collaboration. MARC staff provides training for regional stakeholders on the use of this system to initiate notification to the group. Conference call capability is maintained through MARC. Upon notification through Citywatch, MARC staff will assign a conference call line and communicate the information including phone number and time

of call. It is highly likely that many agencies will move to Phase 2 at the same time. An alert should be done through EMResource to notify the hospitals of the change in Phase and the suspension of hospital diversion, if applicable. The regional WebEOC EMS board should be the primary means of communication between EMS agencies, hospital emergency preparedness, and emergency management until the crisis has resolved. When the regional board is activated, users should identify themselves on the board with their preferred contact phone number for use during plan activation. Depending on locale, messages on this board automatically post to the regional board or the user checks a box to send the message from their local board to the region. Additional conference calls at regular intervals are also suggested if the event will last multiple operational periods.

Local entities should have a notification process in the event they implements all or part of their local plan. Included in the process should be employees and staff of the entity as well as external stakeholders, i.e. the governing body, the public, regional EMS services, hospitals, public health, emergency management, first responders, law enforcement, suppliers, and fleet services. Contact lists and methods of notification (pagers, email, EMResource, WebEOC, etc) should be maintained as an attachment to the local plan and updated regularly.

IX. Increasing Capacity through Pre-planning Reactions and Employee Education

MARCER does not control any assets and is not an operational entity in the event of a crisis. Local entities should have a plan to increase capacity in the face of a crisis situation. Examples of local reactions are included in the appendices. Pre-planning these reactions and educating personnel on their role is vital to successful implementation of the plan and protection of the community. Consideration should be given to the families of employees to make sure their needs are addressed.

X. Pre-Incident Assessment/On-scene Size-up

The region has sufficient pre-hospital resources to handle daily call volume and moderate surges in volume. However there are circumstances which may severely tax the system for an hour up to several days. The goal of each local agency is to look at the hazards outlined in the Mission and develop general plans to modify operations and increase capacity to meet the demand. This is vital due to the need to educate staff, governing bodies, other agencies, and the public on the plan in advance.

A component of the plan that must filter down to field providers is on-scene size-up. They are the eyes and ears looking at the ice-covered interstate full of vehicles or the demolished multi-story building. A rapid assessment of the number of potential injured and scope of the emergency will assist the local agency to determine if operational changes are needed to meet the demand. This may occur long before FirstWatch triggers have been tripped.

XI. Current Capabilities

The region has 34 ambulance services that provide either advanced or basic life support. These services handle emergency and non-emergency requests for pre-hospital treatment and transportation on a daily basis. At a mass casualty incident (MCI), EMS is expect to be able to set up a Medical Branch, Triage, Treatment, Transport, Medical Supply and Medical Communications sectors and may be asked to staff a Rehab sector. The region has purchased and local services maintain caches of trauma supplies that can be

dispatched to an MCI to support operations. The operational guidelines for these events are addressed in the MARCER Regional MCI Plan and in local MCI plans.

The RHDP is designed to address events that are not isolated to a specific location or that are so large in scope that the region will be affected for multiple operational periods. At the most extreme, these events will require prioritizing requests for service, deciding that certain requests will not receive a response, modifying the treatment the patient receives in the field to minimize on-scene time and transport only those who genuinely need the resources of an emergency room.

MARCER will facilitate access to Citywatch, FirstWatch, EMResource and the WebEOC EMS board for these local contacts to facilitate monitoring of regional triggers. MARC will provide access to conference call capability to coordinate activities in the event of a critical situation.

XII. Resolution/Termination of the Event

An individual EMS agency will develop procedures to de-escalate in an orderly manner, often in conjunction with neighboring EMS agencies. Conference calls and the use of WebEOC will be the primary means of coordination of de-escalation. Hospitals should be alerted through EMResource when an EMS agency is de-escalating.

XIII. After Action Review and Improvement Plan

Within thirty (30) days of implementation of the RHDP, MARCER will convene a group of interested and affected parties to discuss the implementation of the plan, analysis of the outcomes, and develop recommendations for changes in the plan, if applicable. MARCER leadership will consider revision of this plan based on the recommendations. Any revisions will be distributed to the EMS community in a timely manner.

XIV. Appendices

Reactions

Individual EMS agencies will determine their specific responses to the trigger alerts and phase changes. The following six categories provide a matrix to analyze operational areas and organize necessary modifications. Individual agencies should be aware during their planning process that neighboring agencies may be making operational changes and may be unable to provide mutual aid. Plan accordingly.

Related to this plan are the hospital plans for surge capacity and the use of alternative care sites. Activation of those plans may coincide with activation of this plan. Coordination with the hospitals is vital to deliver the correct patient to the correct location. Service medical directors must grant permission for individual service to modify medical protocols or to transport patients to alternate sites.

Administration

- Phase 0: normal operations. Regular administrative functions such as meetings, training, inspections, maintenance, billing, quality improvement, and business affairs are conducted.
- Phase 1: some regular administrative functions such as training classes or inspections may be postponed. Administrative staff may report if after hours. Temporary staffing of backup units may occur. Fleet services focuses getting units in service. Quantities of medical supplies on-hand should be reviewed and an immediate-need supply list developed in case the situation worsens. A

department operations center (DOC) may be established and the FirstWatch Dashboard, EMResource and WebEOC EMS board may be monitored.

- Phase 2: administration assumes Incident Command roles and the DOC is activated. Focus is on providing emergency services to the community. Routine daily activities are suspended. Responses and staffing may be modified. Off-duty staff may be recalled and shift schedules may be modified. Fleet services should be staffed to provide repairs as needed. Assistance from Emergency Management may be needed to acquire necessary supplies and coordinate efforts with local government. Fuel for the units and food for staff may have to be acquired. Consider coordination with regional EMS assets. The FirstWatch Dashboard, EMResource, and WebEOC should be utilized to coordinate response and recovery efforts.

Communications

- Phase 0: normal operations. Emergency and non-emergency calls handled per standard procedures. Pre-arrival/post-dispatch instructions provided to callers.
- Phase 1: additional personnel may be required to handle increased telephone/radio traffic. Some delays in non-emergency calls may occur due to emergency call volume. Pre-arrival/post-dispatch instructions may be amended or interrupted by additional emergency calls.
- Phase 2: additional personnel required to handle increased telephone/radio traffic. Tactical radio channel use may increase and radio traffic from the field may be brief. Personnel may be assigned to specific tasks rather than handling multiple tasks. Communications staff may be assigned to the Emergency Operations Center/backup communications center. Pre-arrival/post-dispatch instructions suspended due to the need to handle incoming call volume. Supervisors may have to prioritize responses and amend response configurations in conjunction with the Incident Commander.

Medical Direction

- Phase 0: medical care provided under approved medical protocols and online medical direction.
- Phase 1: consider implementing special EMD protocols, i.e. Card 36, in response to an identified health threat. Other approved protocols and online medical direction remains unchanged. Work with public health and hospitals to identify information concerning health emergencies and communicate that to crews through Administration. Monitor hospital status and facilitate movement of patients out of the emergency room, if appropriate.
- Phase 2: approve implementation of pre-designated modified medical protocols and suspend the use of pre-arrival/post-dispatch instructions. Online medical control use rarely. Consider approval of alternate destinations such as urgent care centers and alternative care sites. Approve suspension of hospital diversion and transport to the closest appropriate facility.

Field Providers

- Phase 0: normal operations. Treatment provided and destination facilities chosen based on approved medical protocols and online medical direction.
- Phase 1: be aware that an increased call volume may increase hospital diversions and turnaround times. Return units to service and return to service area as quickly as possible. Keep scene times to a minimum and provide treatment while transporting. Be alert to regional health issues and alert receiving facilities of potentially contagious patients, i.e. flu patients.
- Phase 2: transport to the closest appropriate facility. Hospital diversion may be suspended. Pre-designated modified medical protocols may be approved. Alternate care sites and urgent care centers may be approved as destinations. First responders may be handling certain low-acuity calls without an ambulance. Radio traffic should be as brief as possible. Online medical direction should

be used rarely. Emergency calls may be holding for an extended period of time, waiting for resources to send.

Hospitals

- Phase 0: normal operations geared towards treating patients, minimizing emergency room wait times, and the holding of inpatients in the emergency room. Provide online medical direction to EMS crews. Utilize EMResource as necessary for hospital diversion.
- Phase 1: prepare for increased patient load. Consider additional staff or operational modifications to handle influx of patients. Minimize diversion time as all hospitals will be busy. Consider establishing segregated waiting/treatment areas for symptomatic patients. Minimize holding of admits in the emergency room.
- Phase 2: hospital diversion may be suspended. Patients may be transported to the closest appropriate facility. Increase staffing to handle influx of patients. Consider establishing alternative treatment area on-site for patients with minor symptoms/minimal injuries. Facilitate in-hospital movement of less-critical patients out of critical care areas. Consider movement of patients to lower acuity facilities by alternate means of transport. Consider sheltering patients, families, and staff that cannot leave the facility due to environmental conditions.

Regional EMS Assets

- Phase 0: none activated.
- Phase 1: consider conference call between agencies to assess situation and potential escalation. Consider use of the WebEOC EMS board.
- Phase 2: regular conference calls between agencies. WebEOC EMS board, FirstWatch Dashboard, and EMResource all in use. Consider sending EMS representative(s) to the Regional Healthcare Coordination Center, if opened.

Sample Operational Guidelines

These sample operational guidelines were obtained from the Tulsa/Oklahoma City EMS system. They are provided for reference and discussion by local services.

Weather-Induced Temporary Alterations to Clinical Standards General Orders

The purpose of the Office of the Medical Director's (OMD's) Weather-Induced Temporary Alterations to Clinical Standards General Orders is to promote the delivery of optimal clinical performance in times of severe weather events and concurrently, to endorse personnel safety in the provision of this clinical performance. It is imperative to these goals for our patients and for our colleagues throughout our EMS system that all affected MCB affiliated agencies are participating in this uniform system for temporary alterations to clinical standards when approved by the Medical Director for specified periods of severe weather.

Definition of "Severe Weather Event"

A "severe weather event" **may** be declared by the OMD upon appropriate input from leaders in public safety (EMS Fire, and Police), public health, and local and state government agencies when correlated with best available meteorological information. Examples of events that could constitute an OMD declaration of a "severe weather event" include:

1. High Winds (Tornado, Sustained 50+ mph wind gusts)
2. Wildfires
3. Flooding (Flash floods, sustained heavy rains)
4. Winter precipitation:
    a. Three or more inches of snow or mixed precipitation on the ground or predicted to accumulate in the next 12 hour period;

b. Secondary roads become or remained snow/ice covered;
c. Snow drifts preventing common travel;
d. Sleet/ice or freezing rain covered roadways.

OMD Issuance of Weather-Induced Temporary Alterations to Clinical Standards General Orders
Utilizing the above criteria (and others as individual weather events dictate), upon recommendation by OMD's Director of Clinical Affairs (Western Division, Eastern Division) and with approval by the System Medical Director, the OMD may implement any number of all of the following Weather-Induced Temporary Alterations to Clinical Standards General Orders. Per individual event OMD directives, these orders may be implemented and rescinded incrementally. Weather-Induced Temporary Alterations to Clinical Standards General Orders implemented will be for a period most typically of 12 hours in duration. Individual event OMD directives will be specific as to utilization periods and when extension or rescinding of these general orders becomes effective.

Guideline 1
Emergency Medical Responders (formerly known as First Responders) will cancel EMSA (or mutual aid transport) response to minor motor vehicle collisions when the patient refuses transportation and any injuries are deemed minor. EMSA will NOT need to obtain a signed patient refusal.

Guideline 2
EMSA will have the authority to transport the patient to the closest appropriate hospital facility.

Guideline 3
A patient in cardiac arrest who does not meet the required parameters for termination of resuscitation consideration (e.g. patient is in a shockable rhythm) may be considered for termination at thirty (30) minutes of EMS resuscitation. Contact with the OMD is REQUIRED prior to termination of resuscitation in these instances. The order of contact with OMD shall occur as follows:
Eastern Division: 1st Director East, 2nd Director West, 3rd Clinical Director, 4th Medical Director
Western Division: 1st Director West, 2nd Director East, 3rd Clinical Director, 4th Medical Director

Guideline 4
If, in the paramedic's clinical judgment, the patient's condition has been definitively addressed on scene (e.g. asthmatic with resolution of symptoms after nebulizer treatment) or does not warrant transport to an emergency department (e.g. chest pain without acute change), contact with the EMSA Field Operations Supervisor (FOS) will be made for consultation for the option to not transport the patient. If the FOS has concerns regarding non-transport, secondary consultation will be made first with the respective OMD Director of Clinical Affairs or secondarily with the System Medical Director.

Guideline 5
EMS system responses may be limited to Medical Priority Dispatch System-identified CHARLIE, DELTA, and ECHO level calls only. Requests for service that are triaged for no response will be listed and a follow-up phone call will be made within **six (6)** hours for a patient welfare check. Subsequent phone calls for a patient welfare check will continue in intervals of at least every six (6) hours and will persist until an EMS response can be made or the patient releases the EMS system from a response requirement. Requests for service that are triaged for no response will be advised to immediately redial 9-1-1 should clinical symptoms worsen.

Modified Medical Protocols

When operating in **Phase 2**, automatically offer to transport patients with the following presentations. Minimize scene time and treat enroute.

1. **Paramedic discretion—suspicion of critical illness/injury.**
2. **Altered vital signs (or age-specific abnormal vital signs), including any one of these:**
    a. SBP < 90.
    b. SpO2 < 92%.
    c. RR > 30 (or respiratory distress). Pediatric patients with signs of cyanosis or increased work of breathing.
    d. HR > 100, or delayed capillary refill.
3. **Breathing**
    a. Respiratory distress.
    b. Cyanosis or pallor/ashen skin.
4. **Circulation/Shock**
    a. Signs or symptoms of shock.
    b. Severe/uncontrollable bleeding.
    c. Large amounts of blood (or suspected blood) in emesis or stool.
5. **Neurologic**
    a. Unconscious or altered level of consciousness.
    b. New focal neurologic signs (CVA, etc).
    c. Status, multiple, or new-onset seizure.
    d. Severe headaches—especially sudden onset or accompanied by neck pain/stiffness.
    e. Head injuries with more than brief loss of consciousness or continued neck pain, dizziness, vision disturbances, ongoing amnesia or headache, and/or nausea and vomiting.
6. **Trauma**
    a. Significant trauma with chest/spinal/abdominal/neurologic injury deemed unstable or potentially unstable.
    b. Suspected fractures or dislocations that cannot be safely transported by private vehicle.

Patients with the following may be more ill than they appear:

- Diabetes
- Immunocompromised
- Pregnant
- Coronary Artery Disease
- Respiratory diseases
- Chronic Renal Failure
- Neuromuscular disease

****

When operating in **Phase 2**, consider the patients with the following presentations for transport by EMS, transport by alternate means, or homecare. Minimize scene time and treat enroute.

1. **Abdominal Pain**

    a. **EMS**: Pulsating mass, marked tenderness/guarding, pain radiating into back and/or groin/inner thighs, recurrent severe vomiting not associated with diarrhea.

    b. **POV/Clinic**: Recurrent severe vomiting associated with diarrhea. Patient to go to the emergency room if associated with signs/symptoms of dehydration, to urgent care or clinic if no dizziness nor vital sign changes and normal exam.

    c. **Homecare**: Intermittent vomiting and diarrhea without blood or evidence of dehydration.

2. **Anaphylaxis/Stings**

    a. **EMS**: Patients who have had epinephrine administered for symptoms, patients experiencing airway, hypotension or respiratory symptoms after an allergy exposure.

    b. **POV/Clinic/Homecare**: Patients with itching after exposure. If rapid onset of symptoms, may require EMS transport; if delayed > 1 hour, safe for private transport. All patients with a history of anaphylaxis should be seen in an emergency room if possible. Others may be seen in clinic or urgent care. EMS may administer diphenhydramine prior to clearing scene, up to 1 mg/kg.

3. **Back Pain**

    a. **EMS**: Acute trauma with midline bony spinal tenderness, new onset of extremity weakness, sensory deficits, other neurological changes, incontinence of urine or bowel, urinary retention, or bloody urine, concern for abdominal aortic aneurysm, pain radiating into abdomen or groin/inner thighs.

    b. **POV/Homecare**: Inability to ambulate/care for self.

    c. **Homecare**: Concern for kidney stone, bloody urine.

4. **Behavioral**

    a. **EMS**: Uncontrolled agitation requiring sedation by EMS.

    b. **EMS or LE or POV**: Suicidal ideation—must be left with a responsible party.

    c. **LE or POV**: Other emotionally disturbed patients may be transported at law enforcement's discretion or by other means.

5. **Bleeding (Lacerations, abrasions, or avulsions)**

    a. **EMS**: Patient is on Coumadin or other blood thinner with significant ongoing bleeding or large hematoma.

b. **POV/Clinic**: Significant lacerations after bandaging—heavily contaminated, bite-related, likely to involve foreign body, deep structure injury, sensory/motor deficit—to the emergency room. Lacerations requiring simple repair—consider self-transport to physician's office or urgent care center (however, some offices do not do procedure; patient will need to call ahead).

c. **Homecare**: Abrasions or avulsions not requiring suturing or repair and no significant contamination, minor lacerations that do not require sutures.

6. Burns

a. **EMS**: All chemical or electrical burns, suspected inhalation burn, significant third degree burns, second degree burns to ≥ 5% of body area, second degree burns to face/mouth, severe pain.

b. **POV**: Second degree burns to hands or feet or to other location 1% to 5% body surface area (size of patient's palmar surface).

c. **Homecare**: Second degree burns < 1% body surface area in non-critical location, first degree burns.

7. Cardiac Arrest

a. **EMS**: Witnessed down time ≤ 10 minutes—follow usual resuscitation protocols.

b. Homecare: All others—report death to dispatch and return to service; do not wait for law enforcement or medical examiner arrival.

8. Chest Pain

a. **EMS**: Chest pain or other signs or symptoms suspicious for cardiac ischemia, pulmonary embolus, or other life threat.

b. **POV/Clinic/Homecare**: Chest pain ongoing for > 12 hours a normal ECG, pleuritic chest pain without hypoxia, chest pain reproducible on physical exam to palpation is generally not concerning. Unless there is ECG changes or known cardiac disease, unlikely to require treatment for acute coronary syndrome.

9. Diabetic

a. **EMS or POV**: Any patient on oral diabetes medications with low blood glucose (if transported by POV, must not drive self), critical high glucose or signs of Diabetic Ketoacidosis/dehydration.

b. **Homecare**: Patients with typical hypoglycemia and explanation for low sugar (did not eat, etc) can be left without medical control contact as long as family/friend is present and patient is eating.

10. Environmental

a. **EMS**: Heat-related illness with any alteration in mental status (confusion, decreased LOC), frozen extremity, hypothermia with AMS.

b. **EMS or POV**: Frostbite to face, hands, feet, other location suspected deeper injury, blisters, or frozen to touch.

c. **Homecare**: Heat-related illnesses without alteration in mental status (initiate external cooling at home under supervision of friends/family), minor frostbite with tissues now soft, pink, no blisters, and not involving digits.

11. ETOH/Substance Abuse

a. **EMS**: Very decreased LOC or other confounding issues (head injury, suspicion of aspiration).

b. **LE**: Otherwise may be transported at law enforcement's discretion.

c. Homecare: Patient may be left with a responsible individual who can assist the patient, able to ambulate safety without assistance.

12. Eye Pain

a. **EMS**: Impaled objects or possible penetrating injury to eye, or globe rupture, Chemical exposures (alkaline)—after decontamination and initial rinsing.

b. **EMS or POV/Clinic**: Eye pain and/or acute changes to vision should receive transport for urgent evaluation to the emergency room or other qualified clinic, i.e. eye clinic, chemical exposures (non-alkaline)—consult poison control for instructions; transport if symptoms/dangerous exposure.

c. **Homecare**: Chemical exposures (non-alkaline)—consult poison control for instructions; if no symptoms and limited toxicity likely, give instruction sheet.

13. Fever

a. **EMS**: Fever plus altered mental status including confusion, fever plus severe symptoms by paramedic assessment, fever plus seizures, lethargy, stiff neck, rash or blistering.

b. **EMS or POV/Clinic**: $\leq$ 3 months with fever estimated at 100.5 degrees—to emergency room or clinic urgently, $\geq$ 3 months with fever that does not reduce with anti-pyretic or fever lasting more than 5 days—emergency room, urgent care, or clinic.

14. Headache

a. **EMS**: With vision deficit, lethargy, or Section 4 qualifiers (fever, etc.).

b. **POV**: New headaches for patient require assessment; usual headaches for patient may require treatment.

15. Musculoskeletal Injuries (Isolated)

a. **EMS**: Loss of distal pulses, unable to effectively splint the affected part, neurological changes or deficits, open fractures, displaced fractures or pain requiring injectable narcotics.

b. **POV**: Suspected fractures that are stable and do not require injected analgesia may be splinted appropriately and transported by POV.

c. **POV or Homecare**: Neck pain and back pain after MVC that is delayed in onset and not associated with midline tenderness or neurologic symptoms.

16. Nosebleed

a. **EMS**: Signs of hypovolemia or dizziness upon standing, patient is on blood thinners (Coumadin, lovenox, clopidogrel, etc), continued high blood pressure (SBP > 200) in setting of nosebleed, and continued severe bleeding despite EMS efforts to control.

b. **Homecare**: All others.

17. OB/Pregnancy

a. **EMS**: Imminent delivery, pain in abdomen or back, profuse vaginal bleeding, third trimester (>24 weeks) bleeding, pre-eclampsia—syncope, seizure, altered mental status, SBP ≥ 140.

b. **Homecare**: All other.

18. Swallowing Problem

a. **EMS**: Patient unable to manage own secretions due to pain or obstruction.

b. **Homecare**: All other.

19. Syncope

a. **EMS**: History of coronary disease or heart failure, age ≥ 55, pregnant, chest pain, headache or shortness of breath (or other symptoms concerning to paramedics).

b. **POV/Clinic/Homecare**: Likely dehydration with dizziness preceding the syncope, other underlying medical conditions.

20. Toxicologic

a. **EMS/POV/Clinic/Homecare**: Overdose or other toxic exposure—contact Poison Control and/or on-line medical control. If intentional, see Section 4 Behavioral Health

21. Vulnerable Person in Potential Danger

a. **EMS/LE/POV**: EMS should ensure that person will not be left in dangerous environment. If safe disposition and transport can be arranged and the injuries to do not otherwise require medical evaluation, other transport may be appropriate. {Consider transport to a shelter, if available}

Reference Documents

- Tulsa/Oklahoma City Emergency Medical Service Authority (EMSA) MCB Clinical Administrative Protocols, approved February 2, 2011.
- Hennepin County EMS Council Pandemic Influenza Appendix, approved April 9, 2009.

2014

BI-STATE

KANSAS CITY REGION

ESF 8 ATTACHMENT G

ATTACHMENT G:

Regional Mass Fatality Plan & KCRMORG SOP

ATTACHMENT G. REGIONAL MASS FATALITY PLAN & KCRMORG SOP

Kansas City Region Mass Fatality Incident Plan

Version 2.0

Updated October 2013

Kansas City Region Mass Fatality Incident Plan

I. Introduction

The Metropolitan Emergency Managers Committee (MEMC) has endorsed this document as the Kansas City region's Mass Fatality Incident Plan. A mass fatality incident is any disaster event resulting in a number of decedents of such a type or magnitude as to overwhelm the capabilities and resources of a single, local jurisdiction. By definition, a mass fatality incident inherently depletes locally available mass fatality resources. Because communities vary in size and resources, there is no minimum number of deaths for an incident to be considered a mass fatality event. It is imperative that some level of inter-agency and inter-governmental cooperation occur during a mass fatality incident to provide not only personnel but fixed and expendable resources as well.

Past disasters, such as the Hyatt Regency walkway collapse on July 17, 1981 (which resulted in 114 fatalities) and the Joplin, Missouri tornado of May 22, 2011 (which caused 159 fatalities), significantly challenged local resources and capabilities. The intent of this document is to outline a mechanism for regional partners to provide support to and coordination with a jurisdiction or jurisdictions impacted by a mass fatality incident.

All disasters begin and end locally; therefore, any regional response to a disaster is in fact a support effort to help meet local needs. This Plan is meant to complement, but never supersede, existing local and county emergency operations plans, statutes, ordinances and other legal or regulatory documents. The outcome of this Plan is the establishment of a Mass Fatality Resource Coordinator (MFRC) meant to assist an impacted jurisdiction with locating and deploying resources to support a mass fatality response, thereby allowing the impacted jurisdiction to focus on life-safety response measures.

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II. Record of Changes

Change #	Date	Part Affected	Date Posted	Who Posted
1	7/24/13	Entire Document		MEMC Plans Subcommittee
2	7/24/13	Planning Assumptions		MEMC Plans Subcommittee
3	7/24/13	Regional Mass Fatality Plan Activation; Item 8		MEMC Plans Subcommittee
4	7/24/13	Requesting and Assignment of Resources; Item 7		MEMC Plans Subcommittee
5	7/24/13	Organization and Assignment of Responsibilities; Item vi		MEMC Plans Subcommittee
6	7/24/13	Organization and Assignment of Responsibilities; B.EOC; items iii and vii		MEMC Plans Subcommittee
7	7/24/13	Added ICS Organization Structure with Fatality Management Branch		MEMC Plans Subcommittee
8	7/24/13	Plan Development and Maintenance; Item D		MEMC Plans Subcommittee

III. Record of Distribution

Plan #	Office/Department	Representative	Signature
01			
02			
03			
04			
05			
06			
07			
08			
09			
10			

IV. Purpose, Scope, Situation, and Assumptions

A. Purpose

1. A large-scale disaster event may result in a high number of fatalities and quickly overwhelm a single, local jurisdiction's capabilities. State and/or Federal resources may not be immediately available (or available at all) to support an impacted jurisdiction. The Kansas City region has long recognized the value of regional coordination as a stopgap measure of support prior to the arrival of, or in the absence of State/Federal resources.

2. This Regional Mass Fatality Plan was developed to provide a mechanism for impacted jurisdictions to acquire resources and assistance to help manage mass fatality response operations.

B. Scope

1. This Plan applies to all participating jurisdictions within the Kansas City region.

2. The Regional Mass Fatality Plan does not supersede the authority or powers of any local elected or appointed officials. The Regional Mass Fatality Plan is solely intended to establish a system of support to impacted jurisdictions to help locate and acquire resources to support Mass Fatality Incident response operations. Other types of operations are beyond the scope of this Plan.

3. This Plan:

   i. Describes the processes for activation of the Regional Mass Fatality Plan.

   ii. Describes the expected actions to be taken by the Mass Fatality Resource Coordinator (MFRC). The MFRC is a support position to the actual statutory authority with jurisdiction over the human remains. The statutory authority is the medical examiner or coroner (ME/C), as applicable, for the impacted jurisdiction.

   iii. Provides a listing of regionally available resources to support mass fatality operations.

   iv. Describes what additional resources may be needed to support mass fatality operations.

   v. Does not supersede existing Emergency Operations Plans, local/State/Federal laws and administrative rules.

   vi. Will be incorporated into the Regional Coordination Guide (RCG).

C. Situation Overview

1. The Kansas City metropolitan area is a bi-state region consisting of 116 cities and 9 counties with a total population of nearly two million residents. The region is comprised of the incorporated and unincorporated portions of Johnson, Leavenworth, Wyandotte and Miami counties in Kansas; and Cass, Clay, Jackson, Platte and Ray counties in Missouri.

The region is subject to a variety of natural, manmade and technological hazards that could result in a mass fatality event. Risk Management Plan (RMP) facilities that store or manufacture extremely hazardous substances (EHS) are located throughout the area. A major industrial accident or act of terrorism directed at one of these facilities could potentially result in catastrophic loss of life. Additionally, several other facilities control EHS below RMP reportable thresholds. The Kansas City region is home to numerous transportation corridors: one international airport and several regional airports serve the area as well as rail and bus lines.

Severe thunderstorms and tornadoes pose an annual threat as well. A Greensburg, KS or Joplin, MO tornado scenario overlaying the urban core would almost certainly result in hundreds of dead and wounded. Likewise, cascading effects from fire or flooding could exacerbate the situation and increase the fatality count.

Emerging infectious disease also has the potential to create large numbers of decedents that could overwhelm the entire region as well as the Nation. Though less severe than predicted, the outbreak of novel H1N1 influenza of 2010 demonstrated how rapidly and completely disease can spread.

2. Local Capabilities and Regional Resources

Four Missouri counties in the region (Cass, Clay, Jackson, and Platte) have MOU's in place with the Jackson County Medical Examiner's Office (ME) for mass fatalities planning, resources and response. Ray County has an elected coroner responsible for mass fatality planning and response. The Jackson County Medical Examiner's Office maintains facilities and staff to manage mass fatalities events. For planning purposes, the ME's office has defined a mass fatality event as a disaster incident which causes 40 or more fatalities in the ME's area of responsibility.

The four Kansas Counties in the region (Johnson, Miami, Leavenworth, and Wyandotte) rely on their local County Coroners for mass fatalities response, and the counties maintain a Mortuary or Mass Fatalities Annex in their local EOPs.

Kansas City Regional Mortuary Operational Response Group (KCRMORG).

The region invested in developing components of a mobile morgue to include a refrigerated trailer to support mass fatality operations. These assets are housed at the Jackson County Sheriff's Office and maintained by the Jackson County ME's office. To operate the mobile morgue, the region has developed a Kansas City Regional Mortuary Operational Response Group (KCRMORG). KCRMORG's mission is to provide the personnel and resources to facilitate an organized and effective response to mass fatality events. The KCRMORG utilizes regional personnel, resources and capabilities to recover, transport, process and identify decedents of a mass fatality event occurring in the Kansas City metropolitan area. Team members are trained in the functional areas of site recovery of decedent remains, morgue operations and working with the Victim Information Center (FAC). KCRMORG has developed and operates under a standard operating procedure (SOP) maintained by the KCRMORG Command Staff. The KCRMORG is activated upon request from an impacted jurisdiction's medical examiner/coroner through local emergency management via the Region A Mutual Aid Coordinator (for jurisdictions in Missouri) or the Johnson County Communications Center (for jurisdictions in Kansas). Procedures for requesting activation of the KCRMORG are found in Appendix C.

Appendix A lists both local and regional Mass Fatality resources and response capabilities.

3. Anticipated Local Jurisdiction Actions and Responsibilities
This Plan only applies to the regional coordination of resources to support a Mass Fatality Incident. Jurisdictions impacted by a disaster are the sole authority for management of that disaster. External to the scope of this Plan, impacted jurisdictions are responsible for:

   i. Tactical resource operations

   ii. Incident command

   iii. Operations management, including:

      1. Temporary morgue site operations

      2. Victim Information Center operations

      3. Other local level operational responsibilities

   iv. Authorities and Limitations for Requests for State and Regional Resources

      1. Requests for resources to the State of Kansas or the State of Missouri must be coordinated by the impacted jurisdiction via an official request, as outlined in the local jurisdiction's EOP.

      2. No resource requests may be made under authority of this Plan outside of the Kansas City metropolitan region.

D. Planning Assumptions

1. There are sufficient factors (including natural, human caused and technological hazards) in the Kansas City area to consider a mass fatality event a credible risk.

2. Multiple deaths may occur during an emergency or disaster.

3. Local systems and resources providing for recovery, victim identification and mortuary services may be insufficient or disrupted by a disaster.

4. Incidents resulting from acts of terrorism will involve the FBI as the lead investigative agency and will require close cooperation and coordination with local authorities

5. Mass Fatality incidents will draw attention from media and curious bystanders

6. Victim identification is a lengthy scientific process that requires great accuracy and attention to detail to ensure that each victim is correctly identified through the necessary methods

7. Families will press for the quick identification and release of their family members; identification expectations must be managed early in the response

8. When activated, KCRMORG utilizes the Victim Information Processing (VIP) form and program to assign a morgue reference number (MRN) to each set of remains as they are being

processed for identification. Once the remains have been identified and released, the receiving medical examiner/coroner is responsible for tracking remains within their own internal structure as necessary.

9. Local capabilities for response vary significantly amongst the partner counties of the Kansas City metropolitan region. Incidents occurring in some areas may not warrant activation of this Plan while in other areas, a similar incident may require activation of this Plan.

10. Impacted jurisdictions may seek assistance from unaffected jurisdictions within the region. Unaffected jurisdictions will provide the assistance sought, as able.

11. The MFRC can identify and request regional resources be brought to the assistance of the impacted jurisdiction.

12. The impacted jurisdiction will notify the State EOC following any Mass Fatality Incident via appropriate channels as outlined in the LEOP or other approved procedures.

13. The coordinating jurisdiction will work with the impacted jurisdiction to request State and/or Federal resources and assistance through the impacted jurisdiction as necessary in accordance with local procedure.

14. Due to financial obligation, requests for assistance from the Disaster Mortuary Operational Response Team (DMORT) should be made only after a Federal Declaration is received.

15. Psychological first aid resources for disaster workers and victims' families may be required following a mass fatality incident.

16. Some responders and their families may likely be victims.

17. Local MOU's/Statewide Mutual Assistance Agreements are place to request resources and extends to participating entities of this plan.

18. State and/or Federal resources may be unavailable for up to 96 hours.

19. A Victim Information Center will need to be established as soon as possible to collect ante mortem data and assist with managing public information and communications to victim families.

20. Volunteers and donations may overwhelm the scene. Consistent messaging and volunteer/donations management will be needed immediately.

21. Local and State jurisdictions will use the National Incident Management System (NIMS) and the Incident Command System (ICS) when managing disasters.

22. Following the initiation of a Fatality Management Branch; daily mass fatality planning and operation components will be included in the Incident Action Plan (IAP) produced by the EOC

V. Concept of Operations

A. General

1. The Regional Mass Fatality Plan does not supersede the authority or powers of any local elected or appointed officials. The Regional Mass Fatality Plan is solely intended to establish a system of support to impacted jurisdictions to help locate and acquire resources to support Mass Fatality Incident response operations. Other types of operations are beyond the scope of this Plan.

2. Prior to the activation of this Plan, agreement(s) should be in place regarding requests for resources from local jurisdictions throughout the region -- what can be expected in the request, who is in command and any other issues that may arise from requesting outside assistance.

B. Regional Mass Fatality Plan Activation

1. This Plan will be activated, when applicable, for any Mass Fatality Incident in the region when a jurisdiction is overwhelmed and needs assistance acquiring resources to support Mass Fatality operations. This Plan may be activated at the direction of the local Incident Commander (IC) or emergency management (EM) director and in conjunction with the medical examiner/coroner of any impacted jurisdiction within the region. Figure 1 below depicts the general flow of Plan activation.

2. The activating authority requests another jurisdiction act as a Regional Mass Fatality Resource Coordinator (MFRC). The MFRC will identify and deploy assets for mass fatality response operations from the Kansas City metropolitan region to the impacted jurisdiction, under operational direction by the impacted jurisdiction's Incident Command and/or EOC.

    i. For incidents involving mass fatalities in multiple jurisdictions, an activated MFRC within the Region will facilitate resource location and deployment for all affected jurisdictions. Depending on the size and location of the incident, consideration may be given to establishing two or more MFRCs, who will work conjointly to coordinate and deconflict resource requests.

    ii. Requests will be prioritized as needed by the MFRC(s), in coordination with expressed needs by the impacted jurisdiction(s).

3. The location of MFRC operations will be coordinated between the impacted jurisdiction and the jurisdiction(s) assuming the role of the MFRC. The MFRC will be managed by the assuming jurisdiction's emergency management director, or designee. The MFRC should be capable of commencing operations within one (1) hour of activation.

4. Each jurisdiction participating in this Plan will be contacted via available communications means (i.e., radio, phone, email, fax, WebEOC) when the Regional Mass Fatality Plan is activated. Every effort should be made to keep event and resource status information current in WebEOC. Supporting jurisdictions will provide contact information to the MFRC.

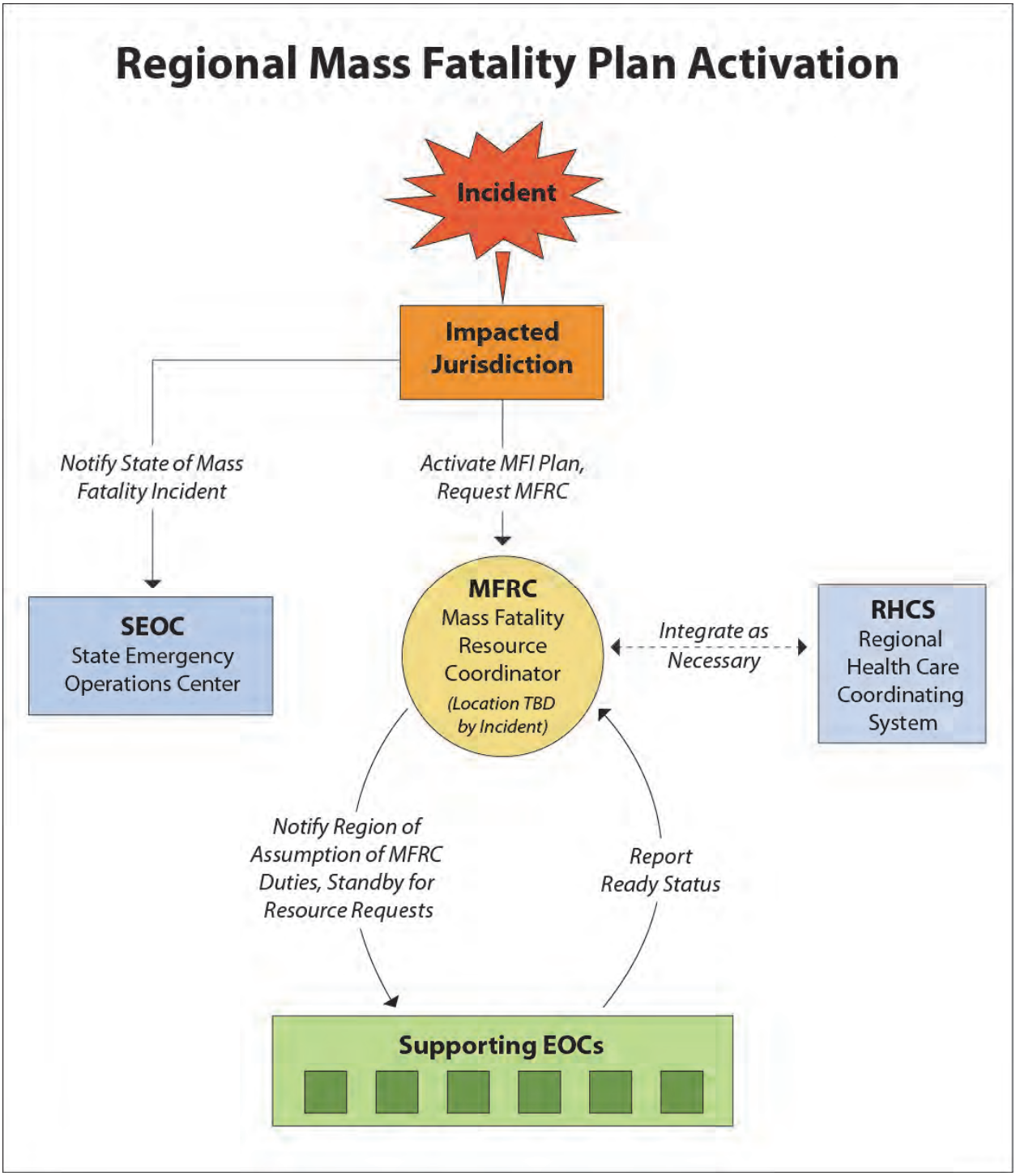
5. Each supporting jurisdiction will communicate the activation of the Regional Mass Fatality Plan to the appropriate local officials, agencies, and volunteer organizations, and begin the activation of EOCs as needed and appropriate.

6. If the Regional Healthcare Coordination System (RHCS) is active, the MFRC will integrate operations (either physically or virtually) with the RHCS.

7. If the KCRMORG is activated, a member of the KCRMORG logistics staff will be stationed with the MFRC. The MFRC should then be responsible for supporting the logistics needs of the KCRMORG.

8. Activities of the KCRMORG will be coordinated with Emergency Management

Figure 1. Regional Mass Fatality Plan Activation Concept of Operations



C. Requesting and Assignment of Resources

1. The MFRC will make every effort to fill all resource requests with resources available within the region. Requests for resources will be made through available communications

means (i.e., radio, phone, email, fax, WebEOC). Figure 2 below depicts the general flow of resources for asset management.

2. If the requested resources are not available within the region, the MFRC will coordinate with the impacted jurisdiction to submit requests to the State EOC in accordance with local procedure.

3. Resources provided to the impacted jurisdiction(s) will normally include the responders or operators necessary to operate the resources. Coordination will be made in all situations where resources are provided without responders or operators so the impacted jurisdiction(s) can make the necessary arrangements. Resources will be coordinated by initially assigning them to a designated staging area. Depending on the event, multiple staging areas may be established.

4. Once resources are established at the staging area, the impacted jurisdiction(s) shall assign the resources based on its operational needs.

5. Emergency response personnel, public and private employees will function within the impacted jurisdiction's ICS while remaining under the administrative supervision of officials from their jurisdiction, organization or company, unless specifically waived by their jurisdiction, organization or company.

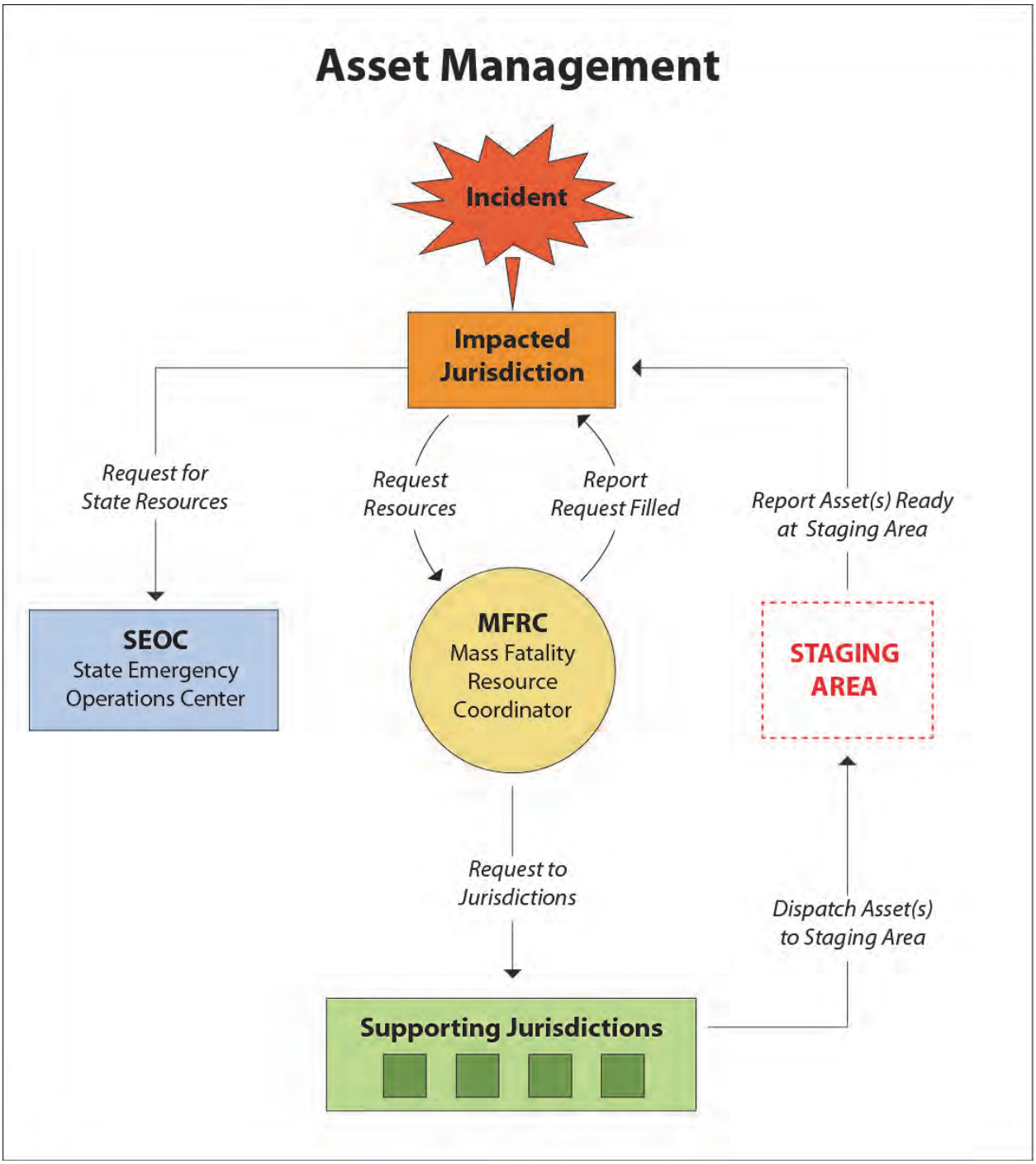
6. It is recommended that Federal Disaster Mortuary Operational Response Team (DMORT) victim identification profile (VIP) documentation should be used to further enable a seamless integration with DMORT should those assets be requested.

7. DMORT will integrate into the regional resource morgue operational structure and will function under the authority of the local ME/C in which the incident occurred. If the incident impacts multiple jurisdictions then the authority will reside with the ME/C with responsibility of the largest number of fatalities.

8. Victim Information Centers (FACs) will be identified, established and operated individually by impacted jurisdictions. MFRC resources may be tasked to assist with FAC operations.

9. For pre-planning purposes, a listing of potential resources that may be requested to support Mass Fatality operations is included in Appendix B.

Figure 2. Resource Requests and Asset Management Concept of Operations



D. Regional Mass Fatality Plan Deactivation

1. The MFRC will provide assistance to mitigate issues involving fatalities to the impacted jurisdiction until the impacted jurisdiction is capable of resuming normal, steady-state operations and has indicated deployed resources from the Region may demobilize and return.

2. The MFRC will continue to track regional assets identified and mobilized by the MFRC as part of this Plan, until they are demobilized from the operational areas, staging area(s) or elsewhere and until returned to their area of origin. All documentation pertaining to these assets will be maintained at the MFRC and forwarded onto the impacted jurisdiction's Finance and Accounting Section Chief via the Emergency Management Director.

3. Once all assets have been returned to their areas of origin, or the impacted jurisdiction has determined there is no longer a need for the MFRC to continue operations, the MFRC will revert back its previous status and notify the impacted jurisdiction of cessation of operations.

E. Responder Safety

Consideration must be given to the enormous demands placed upon responders to a mass fatality incident. Local plans should consider provisions for welfare and psychological support for all responders. Such support measures should include the following:

1. The provision of a separate rest area, away from media and from the bereaved

2. Monitoring responders, who may, because of family bereavement, illness, relationship problems or other similar problems, could be considered to be vulnerable to external factors

3. Consideration of any long-term impact on responders (with appropriate monitoring and support initiatives)

VI. Organization and Assignment of Responsibilities

A. Primary Responsible Parties (within the framework of this Plan)

1. Impacted Jurisdiction. Within the framework of this Regional Plan, the impacted jurisdiction is responsible as follows:

   i. ME/C

      1. The ME/C serving the impacted jurisdiction is responsible for the management of human remains in all Mass Fatality Incidents

      2. Assess the need to activate the Regional Mass Fatality Plan in conjunction with the EOC

      3. Assign roles and responsibilities to responding agencies

      4. Establish a staging area for incoming resources

      5. Establish access authority and credentials

      6. A senior representative from the ME/C office who has decision making authority will be assigned to the UC

ii. EOC

1. Assess the need to activate the Regional Mass Fatality Plan in conjunction with the ME/C
2. Request a jurisdiction to act as MFRC
3. Notify the State EOC regarding activation of this Plan; A senior representative from the ME/C office who has decision making authority will be assigned to the EOC
4. Maintain open communication with the MFRC
5. Request additional resources and/or personnel from the MFRC and/or State EOC
6. Inform the MFRC of local procedures and requirements to track resources and provide tools to assist in these requirements when practicable and applicable.
7. Include the Mass Fatalities planning and operational activities in the response and document activities in the Incident Action Plan (IAP)

2. Mass Fatality Resource Coordinator (MFRC)
Though the primary responsibilities of the response efforts fall on the ME/C, the impacted jurisdiction's EOC will coordinate with the MFRC to acquire needed and requested resources to the affected area. The MFRC maintains no direct authority to initiate this Plan or obligate any unaffected jurisdiction to allocate, purchase or otherwise procure resources for subsequent deployment. The MFRC is responsible for:

i. Designating an individual to manage and coordinate MFRC operations. This may be the EM Director, or designee.

ii. Coordinate operational period requirements with impacted jurisdiction

iii. Contact all regional jurisdictions not affected and alert them that the Regional Mass Fatality Plan has been activated and to await resource requests

iv. Receive and process requests from the affected area's EOC

v. Locate, obtain and track requested resources from deployment to staging areas or other areas as designated by the impacted jurisdiction until deactivated.

vi. Maintain open communication with the impacted jurisdiction

vii. Provide necessary documentation for reimbursement process in accordance with impacted jurisdiction procedures.

3. Supporting Jurisdictions

Supporting jurisdictions are responsible for providing resources via the MFRC to assist the impacted jurisdiction. They are responsible for the following:

i. Activate EOC's (as appropriate) in response to notification of a mass fatality event.

ii. Notify the MFRC when active and ready to respond to resource requests; notify appropriate local officials

iii. Maintain current information in WebEOC regarding the status of resources

iv. Dispatch and track resources responding to the incident in accordance with local procedures

4. KCRMORG

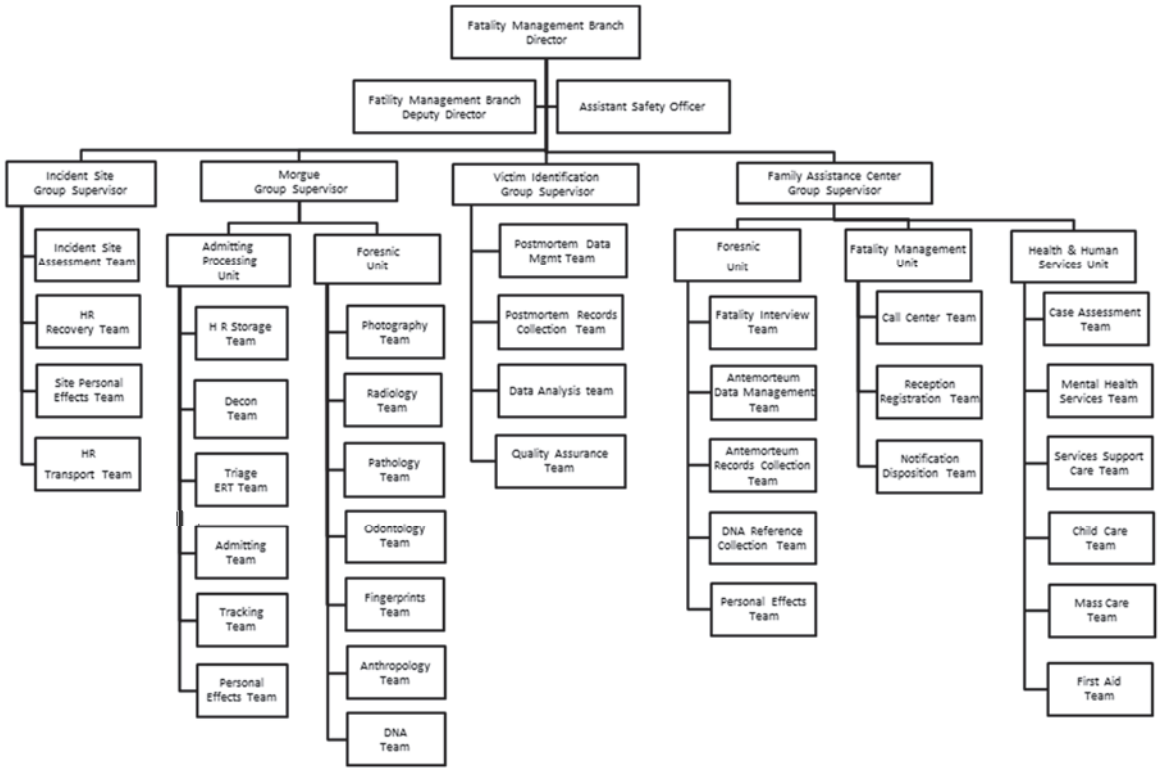
KCRMORG reports to and functions under the operational authority of the local ME/C. Within the framework of the Regional Mass Fatality Plan, KCRMORG is responsible for:

i. Designating logistics personnel to coordinate with the MFRC for logistics request.

ii. Submit logistics requests through the MFRC.

iii. Provide necessary administrative reports to MFRC for tracking and utilization of resources.

Figure 3. ICS Organization Structure with Fatality Management Branch



VII. Authorities and References

A. Legal Authority

1. Federal
    - i. The Robert T. Stafford Disaster Relief and Emergency Assistance, Public Law 93-288 as amended.
    - ii. Presidential Decision Directive 5 (PDD-5).
    - iii. Presidential Decision Directive 8 (PDD-8).
    - iv. Health and Human Services Health and Medical Services Support Plan for the Federal Response to Acts of Chemical/Biological Terrorism.
    - v. Title III of SARA, Public Law 99 499, dated October 17, 1986.
    - vi. Targets Capability List (TCL)
2. State
    - i. Kansas: K.S.A 16-301 through 16-314; 17-1305; 48-3403; 65-1701 through 65-1768; 65-2401 through 65-2438
    - ii. Missouri: RSMo Chapter 58
3. Local
    - i. Local Emergency Operations Plans
    - ii. Medical Examiner/County Coroner Plans
    - iii. County Emergency Operations Plans
    - iv. KCRMORG SOP
4. Volunteer, Quasi-Governmental
    - i. Act 58 4 1905 American National Red Cross Statement of Understanding, December 30, 1985.
    - ii. Salvation Army Charter, May 12, 1974.
5. DMORT protocols and forms can be found in the RCG.

B. References

1. Comprehensive Preparedness Guide (CPG) 101 v2, November 2010.

2. National Incident Management System, Department of Homeland Security, December 2008.

3. National Response Framework, Federal Emergency Management Agency, January 2008.

VIII. Terms and Definitions

A. Mass Fatality Incident - a disaster event resulting in a number of dead of such a type or magnitude as to overwhelm a single, local government's capabilities and resources.

B. Impacted jurisdiction – a local government affected by disaster resulting in a mass fatality incident.

C. Supporting jurisdiction – a local government who provides resources to support an impacted jurisdiction's mass fatality operations via the Mass Fatality Resource Coordinator

D. ME/C – Medical Examiner/Coroner

E. MFRC – Mass Fatality Resource Coordinator

F. RHCS – Regional Healthcare Coordination System

G. EOC – Emergency Operations Center

H. IC – Incident Commander

I. ICP – Incident Command Post

J. DMORT -- Disaster Mortuary Operations Response Team

K. MOU – Memorandum of Understanding

L. FAC – Victim Information Center

M. KCRMORG – Kansas City Regional Mortuary Operational Response Group

Appendix A: Local and Regional Mass Fatalities Resources

First Call Morgue		
Category	Sub-Category	Information
Facility	Morgue	Privately owned: Crime Scene Cleaners 80 N. 18th Street Kansas City, KS 66102 913-909-4264 800-909-2939
	Counties Served - KS	Allen Anderson Atchison Barton Bourbon Brown Chase Chautauqua Cherokee Clay Cloud Coffey Dickinson Doniphan Douglas Ellis Finney Ford Franklin Greenwood Jackson Jasper Jefferson Jewell Johnson Labette Lane Kansas Lansing Correctional Facility Leavenworth Lincoln Linn Lyon Marshall Miami Mitchell Montgomery Morris Nemaha

		Osage Ottawa Pottawatomie Riley Rooks Rush Saline Shawnee Smith Wabaunsee Wilson Woodson Wyandotte
	Counties Served - MO	Buchanan Clinton DeKalb Henry Jasper Johnson Livingston
	Storage Capacity	100 bodies
	Examination Capacity	4 at a time (drainage capacity) 6 at a time (space capacity)
	Supplies – Body Count	150 – 200 (supplies include everything to examine and take samples from a body)
	Power	Electrical line 65Kw generator sufficient to run entire facility – run off natural gas or has propane tank (no supply agreement at this time)
Transport	Vehicles	1 van (can call on 6 others)
Personnel	Staff	2 on hand Additional – 3 from Topeka, 1 more from Johnson Co.
Communication	Common	Phone line
	Network	Internet access via line (not satellite)
	Radio	Police/Fire dispatch VHF set Ham radio
Documents	EOP	Maintained by each county
	Agreements	All informal – Kansas Funeral Director Association Can call on other judicial district coroners Local morticians for Victim Information Center
Additional Resources	Equipment	From Kansas Department of Emergency Management
Other Items	Mobile Morgue	None
	On site	Preliminary examination at scene Can release bodies on site if: 1) positive ID, 2) family contacted, 3) mortuary ready to accept, and 4) no other reason to hold the body

Jackson County Medical Examiner		
Category	Sub-Category	Information
Facility	Morgue	Jackson County Medical Examiner's Office 660 E 24th St. Kansas City, Missouri 64108
	Area Covered - MO	Cass, MO Clay, MO Jackson, MO Platte, MO
	Storage Capacity	60 total bodies – (approximately 20 bodies in storage during normal operations); (5) autopsy suites
Documents	EOP	EOP Maintained by Jackson County Emergency Prep Coordinator; ME's office maintains Mass Disaster Plan and internal SOPs
Other	On site	Preliminary examination at scene Can release bodies on site if: 1) positive ID, 2) family contacted, 3) mortuary ready to accept, and 4) no other reason to hold the body

KCRMORG and Mobile Morgue – Jackson County Medical Examiner		
Storage Location	Jackson County Sheriff's Office 3310 N.E. Rennau Dr. Lee's Summit, MO 64064	How to access – Contact Jackson County Medical Examiner's Office: (816) 881-6600
Category	Sub-Category	Information
Equipment	Examination Capacity	16 tables; 4 instrument pans; 4 instrument carts; components to support all sections of mortuary operations: Admin; X-Ray; Pathology; Personnel Effects; Dental; Fingerprinting; DNA; Anthropology; etc.
	Supplies – Body Count	Adequate supplies to process 80-100 decedents
	Power	(2) 5.5 Kw portable generator; gasoline
	Morgue Facilities	The region is in the process of pre-identifying suitable temporary morgue facilities. *Requirements:* • *10, 000 -15,000 sq. ft. of floor space;* • *Tractor trailer accessible* • *10-foot by 10-foot door with loading dock access (preferable) or ground level* • *Convenient to scene* • *Completely secure (away from families)* • *Easy access for vehicles & equipment* • *Single source of cold water with standard hose bib connection* • *Water hoses, hot water heaters, sinks, and connectors in the DPMU* ***Communications Access***

		• *Existing telephone lines for telephone/fax capabilities* • *Expansion of telephone lines may occur as the mission dictates* • *Broadband Internet connectivity* ***Sanitation/Drainage*** • *Pre-existing rest rooms within the facility are preferable* • *Gray water will be disposed of utilizing existing drainage* • *Biological hazardous waste, liquid or dry, produced as a result of morgue operations, will be disposed of according to local/state requirements*
	Mobile Storage	53' 2011 Great Dane refrigerated trailer with: WALTCO 3300 lbs lift gate, 6500-10 HP diesel generator, (4) LED cargo lights, (5) Exterior Flood lights (2 each side-1 rear), e-track system
Staffing	Kansas City Regional Mortuary Operational Response Group (KCRMORG)	The mobile morgue is staffed by approved KCRMORG team members. Upon activation, the KCRMORG commander will determine personnel needs and make notifications.

Missouri Funeral Directors' Association		
Category	Sub-Category	Information
Location/How to Access	Jefferson City, MO	Accessed by request through Missouri State EOC
Equipment	Trailers	(3) 20' storage trailers (lack prime mover)
	Generators	(4) 15 Kw w/lights
	Body bags	900 heavy duty, 300 bariatric, 3500 typical (non-handle)
	Communications	Radios (number unspecified)
	Digital Cameras	(number unspecified)
	Embalming Stations	(4) with 25 stainless steel exam tables

Kansas Funeral Directors' Association		
Category	Sub-Category	Information
Personnel	Funeral Directors	Volunteers capable of supporting FAC and other mass fatality operations as qualified and available.

Appendix B: Potential Resources Needed to Support Mass Fatality Operations

- Site location for temporary morgue (see Appendix A for site specifications)
- Gray water removal services (if no existing utilities)
- Potable water services (if no existing utilities)
- Generators (if no existing utilities)
- Refrigerated trailers (53' preferred)
- Logistics support for KCRMORG team members (lodging, food, etc.)

Appendix C: Procedures for Activating KCRMORG

For jurisdictions in Kansas:

1. Contact Region the Johnson County Communications Center Dispatch at: 913-826-1000
2. Provide dispatch with assessment of situation and what is being requested.
3. Provide dispatch with name and contact information of requesting individual.
4. Provide dispatch with any other relevant information to relay to KCRMORG commander.
5. Dispatch will contact on-duty KCRMORG personnel and relay request. KCRMORG personnel will contact requesting jurisdiction and arrange for deployment.

For jurisdictions in Missouri:

1. Contact Region A Mutual Aid Coordinator (Lee's Summit Fire Department) Dispatch at: 816-969-7407
2. State "Region A Mutual Aid Request for KCRMORG".
3. Provide dispatch with assessment of situation and what is being requested.
4. Provide dispatch with name and contact information of requesting individual.
5. Provide dispatch with any other relevant information to relay to KCRMORG commander.
6. Dispatch will contact on-duty KCRMORG personnel and relay request. KCRMORG personnel will contact requesting jurisdiction and arrange for deployment.

Kansas City Regional Mortuary Operational Response Group

Standard Operating Procedures

Rev-1

January 2014

Kansas City Regional Mortuary Operational Response Group Standard Operating Procedures

EXECUTIVE SUMMARY

Record of Changes

These SOPs will be reviewed at least annually and/or after a significant event, exercise or training. Necessary modifications or changes to these SOPs will be recorded below.

Date of Change	Section/Page #	Name of Person/Organization	Comments
4/26/13	Entire document	KCRMORG	Changed "Family Assistance Center" to "Victim Information Center"
7/24/13	Entire Document	KCRMORG	Changed "Victim Identification Center" to "Victim Information Center"
7/24/13	Summary of Procedures; Page 3	KCRMORG	Added triage to Morgue Sections
7/24/13	1.2 Jurisdictional Responsibility and KCRMORG Support; Page 11	KCRMORG	Added definition of jurisdictional authority for ME/C for an incident that occurs in multiple jurisdictions
7/24/13	1.3.3 KCRMORG Logistics Support and Regional Mass Fatality Plan; Page 13	KCRMORG	Added Emergency Managers to the KCRMORG planning team
7/24/13	Site Selection; Page 19	KCRMORG	Added the coordination of site selection with EOC
7/24/13	11.0 Regional Activation Checklists; Page 44	KCRMORG	Added Regional Activation Checklists for Activation, Operations and Demobilization
7/24/13	12.0 Operational Briefing Agenda; Page 48	KCRMORG	Added a sample operational briefing agenda to include Mass Fatalities reporting

Kansas City Regional Mortuary Operational Response Group (KCRMORG) Standard Operating Procedures (SOP) for Mass Fatality Incidents

Executive Summary

These SOPs delineate the general procedures used for KCRMORG operations when activated. They are designed to provide public safety, public health, medical examiners, coroners, and other emergency management, medicolegal and emergency response stakeholders with accurate information in reference to how KCRMORG operates in the response to mass fatality incidents involving a number of fatalities exceeding the resources available to a local jurisdiction.

These SOPs were created to give structure to KCRMORG operations using the well-established victim identification procedures utilized by DMORT. The legal responsibility of the ME/C to identify disaster victims is codified throughout the United States, and it is maintained when a mass fatality incident occurs. The capabilities and resources of ME/C's in the Kansas City region vary; a standardized KCRMORG system allows for disaster victim identification to be managed at a consistent level anywhere in the region.

While no set of SOPs can address every and all contingencies, this set of comprehensive procedures has been created and designed to provide standardized and approved strategies, approaches, and processes to manage the unidentified deceased with dignity and respect. Certain modifications might be required based on extenuating circumstances that cannot be foreseen. In those cases, key stakeholders should confer and develop the approach to these circumstances that best meets the mission requirements. In all other circumstances, implementing these procedures will serve as the reasonable and prudent approach to managing an incident or event in which mass fatalities require retrieval, identification, and processing.

The SOPs commence with a Summary of Procedures for the jurisdictional ME/C. This Summary of Procedures is the basis for an initial briefing between KCRMORG representatives and the ME/C that has requested KCRMORG assistance.

Section 1.0 is the introduction and overview of the SOPs. It contains the concept of operations or CONOPS. It provides a high-level introduction and strategic overview to the KCRMORG system. It provides an overview of victim identification and mass disasters. This Section describes jurisdictional responsibility and regional and KCRMORG support. Also covered in this Section are how the KCRMORG is activated and critical initial meetings with local representatives in order to discuss and identify mission strategies and objectives, as well as the organizational, legal, and political realities, expectations, and limitations.

Section 2.0 contains all of the procedures that direct incident site operations entailing transportation to the Incident Morgue.

Section 3.0 is the procedures directing incident morgue operations including: site selection, deployment and activation of a portable morgue, security, and photography procedures.

Section 4.0 provides guidance for the documentation and analysis of remains. This section includes the forensic processes, morgue flow, radiology, odontology, pathology, anthropology, DNA, and data management.

Section 5.0 outlines and directs Victim Information Center operations.

Section 6.0 directs the process for making identifications.

Section 7.0 includes information and procedures on death certification and notification.

Section 8.0 provides direction on the final preparation of the deceased and managing the final disposition of remains.

Section 9.0 addresses demobilization of the incident morgue and termination of activities of the KCRMORG mission.

Section 10.0 addresses the development of an After Action Report (AAR) for all KCRMORG missions.

For Medical Examiners and Coroners: Summary of Procedures

A mass fatality event is any disaster event resulting in a number of decedents of such a type or magnitude as to overwhelm the capabilities and resources of a single, local medical examiner/coroner (ME/C). Because communities vary in size and resources, there is no minimum number of deaths for an incident to be considered a mass fatality event. Mortuary capacity may be significantly exceeded and in many communities, there is no mortuary capacity.

The KCRMORG is available to assist with collection, documentation and retrieval of the deceased, transportation of human remains to the incident morgue, processing for identification of the dead, final disposition, release of remains and family assistance activities. The KCRMORG is not equipped or trained to process chemical or radiological contaminated remains. Contaminated remains are unsafe to process in the incident morgue and must be decontaminated before removal from the incident site to avoid cross contamination of other areas and people. If remains are contaminated following a WMD event, ME/C's should request Federal DMORT-WMD support.

If the impacted jurisdiction's ME/C determines a need for KCRMORG assistance, requests for activation should be made in conjunction with the impacted jurisdiction's emergency management director and funneled through the appropriate regional mutual aid coordinator. Impacted jurisdictions in Missouri should contact the Region A Mutual Aid Coordinator (Lee's Summit Fire Department) and impacted jurisdictions in Kansas should contact the Johnson County Communications Center. These coordinators will in turn contact the KCRMORG Commander and request activation of the KCRMORG. The KCRMORG Commander will dispatch an initial assessment team to the scene to determine resource and personnel needs. From there, call-down to KCRMORG members will be initiated. To the greatest extent practical and possible, local victim identification teams will be incorporated into KCRMORG operations. The initial assessment team will meet with the ME/C to:

- Ensure that the ME/C jurisdictional responsibility is understood and maintained.
- Assess ME/C needs for completing the victim identification process.
- Review the role of KCRMORG in supporting ME/C.
- Present an overview of the KCRMORG SOPs.
- Ensure that the ME/C understands complexities of victim identification process.
- Assess facilities for the incident morgue.
- Discuss ME/C role in family briefings.

- Examine potential costs and reimbursement issues.

The incident (or temporary) morgue is the location where the remains are processed by forensic specialists to confirm identification and to conduct a medicolegal exam for determination of cause and manner of death. The impacted jurisdiction will be responsible for securing a suitable facility to house the incident morgue. For specific site requirements, see Section 3.1. Transportation of remains from the incident site or temporary morgue to the morgue site will be professional and dignified.

The morgue flow plan and any specific needs of the ME/C will determine the basic floor plan of the morgue. Morgue sections may include:

- Admitting
- Triage
- X-Ray
- Assessment Pathology
- Personal Effects/Photography
- Dental
- Anthropology
- Fingerprints
- DNA
- Exit and Re-bag
- Embalming and Casketing
- PPE gown/de-gown and disposal

The flow of remains and personnel through the incident morgue is dictated by the physical structure of the facility, the number of morgue personnel, the condition of the remains, and medicolegal considerations. Typical KCRMORG incident morgue operations comprise one twelve-hour shift per day. The number of remains will dictate whether a second shift is warranted.

Triage is an interdisciplinary section consisting of a pathologist, anthropologist, and an odontologist. The role of triage is to sort materials brought from the site in order to:

- Separate human tissues from other material evidence.
- Identify associated remains from non-associated remains.
- Assign probative value to fragmented remains in order to first process those remains most likely to provide evidence of personal identity.
- Separate tissues that are less likely to provide evidence of personal identity and place those remains in a common tissue container for later analysis or disposition.
- Enter remains into admitting for assignment of a morgue number.

Establishing and maintaining a chain-of-custody for personal effects and other pertinent materials verifies the integrity of the evidence. Remains/evidence processing teams will maintain the chain-of-custody throughout the recovery and morgue processes. As with human remains, personal effects must be handled with the care and consideration. Typically, personal effects removed from remains will be managed by the local jurisdiction under their procedures.

Each set of remains will be assigned a morgue reference number (MRN) as a unique identifier. The MRN will be a whole number and assigned in ascending order. Following identification, the ME/C will be able to use their office case number to account for decedent remains.

Trackers accompany human remains through the mortuary process and ensure proper documentation is complete and attached at each morgue station. Trackers are responsible for the collection and safe keeping of all papers and examination records kept in the VPR. (Note: Staffing for trackers may vary according to the particular disaster.)

Photography of remains is an essential and standard process for forensic examination. Each body or numbered fragment will be photographed. KCRMORG personnel can take human remains or scene photographs if required. Photography that is not part of the identification process within the morgue is restricted. For historical and training purposes, certain candid photographs will be allowed. A candid photograph is any photograph taken within the morgue/storage secured area for any purpose other than being a part of the identification process.

The radiologist/X-ray technologist conducts radiographic examinations to detect evidence, provides postmortem radiographs for comparison with antemortem clinical radiographs and assists pathologists, anthropologists, and odontologists in the interpretation of radiographs. It is recommended that ALL remains have radiographs completed to ensure physical items (personal effects, evidence, etc.) are not missed in the processing of remains.

The Dental Section Leader is responsible for the dental team. The Section Leader or other team members may provide support to other agencies (e.g., FBI) and other forensic identification disciplines (e.g., forensic anthropology, fingerprints, radiology). The odontology section comprises the antemortem section, the postmortem section, and the comparison section. Dental personnel may also be asked to support the retrieval of dental remains at the incident site.

The Dental Antemortem Section procures, analyzes, and consolidates dental information into a single, standardized, comprehensive antemortem dental record. A team of no fewer than two trained and qualified individuals will perform all recording and transcription of information.

The Dental Postmortem Section performs the dental autopsy including postmortem dental radiography and photography, and records the results in a standardized format. The postmortem section examinations and data entry will be performed by teams of no fewer than two trained and qualified individuals.

The Dental Comparison Section compares antemortem and postmortem dental information. Comparisons resulting in positive identifications are reported to the Identification Documentation Team and then to the ME/C via the means established for the event.

The examination and documentation of remains in the Pathology Section can provide detailed information assisting in identification, defining injury patterns and determining cause and possibly manner of death. KCRMORG forensic pathologists are available to assist the ME/C as needed.

The Anthropology Section should consist of at least two forensic anthropologists (one of whom is designated as Section Leader) and one assistant to serve as scribe. Staffing and equipment needs may vary according to disaster-specific needs and the functional assignment of the section.

All records and data are kept secure and confidential in the Information Resource Center (IRC). Only authorized personnel are permitted inside the IRC area. Records are evidence and property of the ME/C and all original records will be submitted to the ME/C at the conclusion of the mission. KCRMORG will

not retain any original or copies of records. No information will be released to any person(s) without proper authorization.

The Victim Information Center Team (VICT) supports the ME/C and the local or Federal law enforcement agency by conducting missing persons reporting, interviewing NOK, collecting antemortem data, including DNA reference samples. The VICT then transfers this information to the IRC. If requested, the team will also provide information to the NOK and assist the ME/C with death notifications.

The VICT supports the victim identification process by procedures including:

1. Establishing a command structure to manage VICT staff.
2. Providing trained interviewers for the family interview process.
3. Establishing antemortem data acquisition and entry plan.
4. Coordinating operation with IRC Section Leader.
5. Establishing and supervising death notification procedures with ME/C, and securing psychological, and religious personnel if requested.
6. Serving as a member of the death notification team.
7. Coordinating VIC transportation and security plans for VICT personnel.
8. Working with Federal partners assigned to the C and ensuring proper support for them.

Proper positive identification is necessary for notification of the NOK, resolving estate issues and criminal/civil litigation, and the issuance of death certificates. A team chaired by a designated pathologist from KCRMORG will meet daily to review and confirm identifications. The team will consist of representatives from the forensic science disciplines and the ME/C office. The documentation of the identification, the cause and manner of death, and final disposition are required by law and used for vital statistics and the initiation of probate. The death certificate is the legal instrument for this documentation. The ME/C is responsible for all legal documentation pertaining to death certification.

Remains of decedents must be handled with the utmost respect and care. KCRMORG team members will ensure that all human remains (identified, unidentified, common tissue, or any other types of remains) are stored with dignity, prepared with professionalism, and transported with consideration. Once remains have been identified, they are securely stored in an environment that retards decomposition and maintains the chain of custody. In situations where remains are fragmented and commingled, identified remains may be re-associated so that remains belonging to individuals are returned together to the NOK. Often, because DNA analysis is the method used to conduct these identifications, the physical re-association of remains take place weeks or months after an incident.

The integrity of the identification process and morgue operations demands that remains be reviewed before release from the morgue. This review should include an examination of the identification methods used, a physical examination of the remains, and the proper re-association of remains for each decedent.

Via embalming, thorough disinfection, preparation, and minor reconstructive surgery procedures are accomplished on each decedent or part of decedent when authorized by the appropriate NOK. NOK may contract with a funeral home to perform this function. NOK or legal authority may authorize cremation as the final means of disposition.

Decedents and human remains will be placed in a casket, dressed when appropriate, and relocated to the morgue shipping point. If chosen by the NOK, cremation is an acceptable form of final disposition. NOK or legal authority may contract with a funeral home/crematory for cremation services.

To coordinate the shipping of remains and any NOK considerations, the receiving funeral home must be contacted and information exchanged. There will be coordination for the transport of released human remains from the incident morgue to a designated location, such as an airport for transport to the receiving funeral home.

Once incident morgue operations have ceased, all remains have been released, or there is a requirement to close the morgue operation, a standard process will be used to ensure the morgue site is cleaned, the mobile morgue is packed, and that all remains have been accounted for. The incident morgue facility must be turned back to the owner or agent of the owner without biological contamination. The facility must be restored back to its previous condition. Arrangements will be made through the IRC to provide a walk-through with the owner to ensure that the cleanliness and condition of the facility is satisfactory.

Background

The Kansas City metropolitan area is a bi-state region comprised of 119 cities and Johnson, Leavenworth, Wyandotte and Miami counties in Kansas and Cass, Clay, Jackson, Platte and Ray counties in Missouri. A number of hazards, such as tornadoes or hazardous chemical accidents, exist in the Kansas City region which could potentially cause a mass fatality event. The local medical examiner/coroner (ME/C) remains the sole legal authority to conduct victim identification, determine the manner and cause of death, and manage death certification -- regardless of the size of the event. Realizing the possibility of disaster events to quickly overwhelm a single jurisdiction's capabilities, a Regional Mass Fatality Plan was developed with the primary purpose of assisting resource coordination and support to jurisdictions impacted by a mass fatality event.

In addition to management of mass fatality events, the ME/C is responsible for other medical/legal activities, such as notification of next of kin. Building on the precepts of the Regional Mass Fatality Plan, and to help reduce the burden on a single ME/C, a Kansas City Regional Mortuary Operational Response Group (KCRMORG) was developed to assist the impacted ME/C and provide for an integrated emergency response to an incident. The KCRMORG is intended to be a force multiplier in the absence of or prior to the arrival of Federal DMORT support. This document details the Standard Operating Procedures (SOP) of the KCRMORG.

Mission

The mission of the KCRMORG is to provide the personnel and resources to facilitate an organized and effective response to mass fatality events. The KCRMORG utilizes regional personnel, resources and capabilities to recover, transport, process and identify decedents of a mass fatality event occurring in the Kansas City metropolitan area. Team members are trained in the functional areas of site recovery of decedent remains, morgue operations and working with the Victim Information Center (VIC).

The KCRMORG SOPs were developed in order to provide a comprehensive reference that describes the standard approach to mass fatality management by members of KCRMORG. The SOPs will outline authority, scope, standards and processes to facilitate the execution of approved policy level recommendations by participating agencies and KCRMORG members. Where applicable, these SOPs mirror the standards and processes used by the National Disaster Medical System (NDMS) Headquarters, and Disaster Mortuary Operational Response Teams (DMORT) teams, for operations in the field on any non-transportation related mass fatality incident involving Federal government assets and resources. These

SOPs will provide a standard approach regardless of causative force, geographic location or specific team members deployed. Additionally, these serve as a significant reference in the development of field training programs and exercises for KCRMORG personnel.

Scope

KCRMORG is able to operate throughout the nine-county Kansas City metropolitan area, at the request of the local ME/C. These SOPs are the approved procedures that will be utilized by all KCRMORG members at the disaster site(s), incident examination center(s), incident morgue(s), fatality collection center(s), fatality transfer center(s), and all other facilities established on a specific incident or mission for the purpose of mass fatality management, support, or coordination.

Situation

Four Missouri counties in the region (Cass, Clay, Jackson, and Platte) have MOU's in place with the Jackson County Medical Examiner's Office (ME) for mass fatalities planning, resources and response. The four Kansas Counties in the region (Johnson, Miami, Leavenworth, and Wyandotte) and Ray County, MO rely on their local County Coroners for mass fatalities response, and the counties maintain a Mortuary or Mass Fatalities Annex in their local EOPs.

To support the mission of the KCRMORG the region, in conjunction with the Jackson County Medical Examiner's office, has purchased equipment and supplies (including a 53-foot refrigerated trailer) for a mobile morgue. The mobile morgue will be the primary resource of the KCRMORG and it will deploy with and be operated by KCRMORG personnel. With current equipment supplies and dependent on the condition of remains, the KCMORG has the ability to process 80-100 decedents. State and/or Federal support will be required for mass fatality events exceeding these capabilities, or when morgue operations have the potential to extend past two weeks.

Intended Audience

The intended audience comprises KCRMORG personnel, Medical Examiner/Coroner (ME/C) personnel, and local officials involved in disaster planning and emergency/disaster response.

Command Structure

The KCRMORG is structured in accordance with NIMS/ICS principles. A Commander and two Deputy Commanders oversee the various section chiefs. Command Staff members consist of representatives from various agencies across the metro. Current Command Staff personnel are listed in Appendix A. The KCRMORG Commander maintains a roster of current KCRMORG members. This roster is updated on a periodic basis.

For the full document, contact the Mid-America Regional Council.

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KANSAS CITY REGION

ESF 8 ATTACHMENT H

ATTACHMENT H:

Kansas City Metropolitan Area National Disaster Medical System Plan

ATTACHMENT H. KANSAS CITY METROPOLITAN AREA NATIONAL DISASTER MEDICAL SYSTEM (NDMS) PLAN

I. About

The National Disaster Medical System (NDMS) is a federally coordinated system that augments the Nation's medical response capability. The overall purpose of the NDMS is to supplement an integrated National medical response capability for assisting State and local authorities in dealing with the medical impacts of major peacetime disasters and to provide support to the military and the Department of Veterans Affairs medical systems in caring for casualties evacuated back to the U.S. from overseas armed conventional conflicts.

The National Response Framework utilizes the National Disaster Medical System (NDMS), as part of the Department of Health and Human Services, Office of Preparedness and Response, under Emergency Support Function #8 (ESF #8), Health and Medical Services, to support Federal agencies in the management and coordination of the Federal medical response to major emergencies and federally declared disasters including:

- Natural Disasters
- Major Transportation Accidents
- Technological Disasters
- Acts of Terrorism including Weapons of Mass Destruction Events

Components of the National Disaster Medical System

- Medical response to a disaster area in the form of personnel, teams and individuals, supplies, and equipment.
- Patient movement from a disaster site to unaffected areas of the nation.
- Definitive medical care at participating hospitals in unaffected areas.

II. To Access the Plan

To access the plan, contact the Mid-America Regional Council.

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KANSAS CITY REGION

ESF 8 ATTACHMENT I

ATTACHMENT I:

Kansas City Regional Patient Movement Plan

ATTACHMENT I. KANSAS CITY REGIONAL PATIENT MOVEMENT PLAN

I. Overview

Purpose and Scope

1. This Attachment has been developed to assist in coordinating the movement of patients to other areas in the event local and regional healthcare resources are insufficient to provide the definitive care required for those affected by the event. Specifically, this Attachment:

    a. Identifies who authorizes the forward movement of patients

    b. Addresses transportation considerations for the forward movement of patients

    c. Describes how patients are identified to the state or states (Missouri and/or Kansas) for forward movement within the state(s)

    d. Addresses the process for coordinating with the state to request federal assistance with the forward movement of patients to other states through the National Disaster Medical System (NDMS)

2. This Attachment also describes patient tracking and reporting systems and their use in a mass casualty incident, as well as coordination between hospitals, Emergency Medical Services (EMS) agencies and the local Emergency Operations Center (EOC).

3. This Attachment has been developed for all of the public health and medical agencies and emergency organizations in the nine (9) county Kansas City Metropolitan area represented by the Mid-America Regional Council (MARC).

4. This Attachment is designed to integrate with and complement the existing emergency plans and procedures already maintained by the agencies and organizations throughout the region.

5. This Attachment is designed to be flexible and the extent of its activation will be determined by the nature and scope of the incident. When circumstances warrant, the entire Attachment or specific portions of it may be initiated.

6. This Attachment is one of several components that make up ESF 8. To the extent possible, information contained in other plan components will not be repeated in this document.

Background

1. This Attachment is integrated with and incorporates the principles of several other regional plans including:

    a. Attachment D: MARCER Mass Casualty Incident (MCI) Plan

    b. Attachment K: EMSystem Protocols and Policies Manual

    c. Attachment E: Community Plan for Ambulance Diversion for the Greater Kansas City Metropolitan Area

    d. Attachment H: Kansas City Metropolitan Area NDMS Plan

2. A regional plans index with a brief description of these plans is included in the RCG: Base Guide.

II. Emergency Activities

A. General

1. This Attachment is not designed to be operational, but rather to address the necessary coordination elements required to effectively manage a mass casualty incident or Chemical, Biological, Radiological, Nuclear or Explosive (CBRNE) event.

2. The activities of the EMS agencies, hospitals and healthcare facilities, and other emergency organizations in the region will be governed in accordance with their internal emergency plans and procedures, as well as the local Emergency Operations Plan (EOP) in their jurisdictions.

3. Every effort has been made to ensure ESF 8 complements and supports the activities described in local EOPs and other local emergency guidelines and procedures. In the event of any variance or inconsistency, the information contained in local EOPs and in the procedures, standard operating guides and protocols maintained by the emergency service agencies in the region will supersede the information contained in this Attachment.

B. Pre-Incident (Prevention and Preparedness)

1. Coordination

a. The primary stakeholder in the development of this Attachment is the MARC Emergency Rescue Committee (MARCER). The MARCER is the regional work group responsible for the development of the Mass Casualty Incident Plan, EMSystem Policies and Protocols and the Metropolitan Plan for Diversion. The MARCER meets monthly and facilitates frequent coordination activities with other emergency organizations in the region. MARCER members

include representatives from EMS agencies, hospitals and local Public Health Agencies/Departments (LPHAs/LHDs) throughout the region.

b. In addition to the MARCER, the Regional Homeland Security Coordinating Committee (RHSCC) has established several Subcommittees who meet on a regular basis to improve regional health and medical coordination such as the Hospitals Subcommittee, First Responders Subcommittee, and the Public Health Subcommittee.

c. The Veterans Administration Medical Center (VAMC) participates in coordination and preparedness activities sponsored by the MARC and is an active participant in regional planning efforts including the development of this Forward Movement of Patients Attachment. The VAMC is the Federal Coordination Center (FCC) for the National Disaster Medical System (NDMS) as described under "NDMS Operations".

d. Other preparedness activities related to forward movement of patients (e.g., joint training and exercises) are facilitated by the MARC and other regional emergency preparedness organizations on a regular basis.

C. Incident (Response)

1. General

a. The National Incident Management System (NIMS) will be used to manage an incident involving mass casualties.

b. As prescribed in NIMS, the Incident Command System (ICS) will be used as the management system for response operations throughout the Kansas City metropolitan area. ICS integrates facilities, equipment, personnel, procedures, and communications operating within a common organizational structure.

c. Medical ICS position descriptions and checklists for regional EMS agencies are contained in the MARCER Mass Casualty Incident Plan.

2. Patient Distribution

1. EMS agencies at the scene will work closely with area hospitals to monitor the current and potential patient load resulting from the incident. The Incident Commander and the affected hospital(s) will relay information to local EOCs and LPHAs/LHDs allowing them to anticipate and plan for the potential forward movement of patients as soon as possible.

2. Hospitals will update patient treatment capability information in the EMSystem and EMS agencies may use this information to route patients to facilities with the capacity to treat them.

3. Based on information in the EMSystem and/or relayed to the EOC from the Hospital Incident Commander(s), recommendations will be made by the local Public Health Director and/or the EOC to the on-scene Incident Commander and the Hospital Incident Commander regarding the distribution of patients and the need, or potential need, to activate resources outside the region.

4. The Transportation Officer in coordination with the Hospital Incident Commander(s) will coordinate any necessary patient transfers between facilities. Information regarding the need to

transfer patients from a facility will be relayed through the Hospital Incident Command Structure (HEICS) structure.

i. Patient Tracking

- At this time, each organization has the responsibility to maintain accountability of patient movement through a manual process as identified by their respective organizational protocols and/or guidelines.

ii. Patient Diversion

- Depending on the scope and nature of the incident, standard diversion procedures will initially be used to divert patients from hospitals reporting lack of capacity. All diversion activities will be based on Attachment E: A Community Plan for Ambulance Diversion for the Greater Kansas City Metropolitan Area.

- Diversion will be based on the defined capacities or services of the hospital and should occur only after the hospital has exhausted all internal mechanisms to avoid a diversion. If the regional hospitals in the catchment areas are overwhelmed, the more remote hospitals outside the catchment areas in Cass, Leavenworth and Clay Counties will be considered for patient transport. For more information, see Appendix 2.

3. **Forward Movement of Patients**

a. **General**

i. In the event that the number of ill or injured patients exceeds the capacity of the nine (9) county metropolitan area hospital system to provide the necessary definitive care, patients may be moved to hospitals outside the region for care.

ii. The determination to move patients outside the metropolitan area for care and treatment will be made by the Public Health Director(s) in the affected jurisdiction(s), or their designee in the local EOC, in conjunction with the on scene IC and the Hospital IC.

iii. Local EOCs will maintain contact with their respective State Emergency Management Agency who will activate their State EOC as necessary. The Missouri State Emergency Management Agency (SEMA) EOC will include representatives of the Department of Health and Senior Services (DHSS) and the Kansas Division of Emergency Management (KDEM) EOC will include representatives of the Department of Health and the Environment (KDHE).

iv. In the event patients must be moved outside the region for treatment, the resources of the National Disaster Medical System (NDMS) will likely be requested and NDMS patient transportation procedures will be implemented as described under "NDMS Activation".

b. **Forward Movement Within Missouri and Kansas**

i. Local Emergency Management Agencies (EMAs) and LPHAs/LHDs will maintain communications with their counterparts at the state level (SEMA, KEM, DHSS and KDHE), who will assist with the statewide monitoring and distribution of patients. Information will also be shared with the state via WebEOC.

ii. Once activated, the State EOC will serve as the hub for state wide information management including patient tracking within their respective states. The states will maintain contact with the appropriate federal agencies such as the Department of Health and Human Services (HHS), the Veteran's Administration and the Department of Homeland Security, Federal Emergency Management Agency (DHS/FEMA).

iii. If the healthcare system in the metropolitan area is at or nearing maximum capacity and the resources of the NDMS are unavailable, the two regional hospital plans may be activated and patients may be transported to hospitals in Missouri Region A (thirteen counties in Northwest [NW] Missouri) and/or the Northeast Kansas Region (thirty-four counties in Northeast [NE] Kansas).

iv. Local EOCs and LPHAs/LHDs will coordinate with their state counterparts to activate and utilize statewide hospital resources, particularly those located in the NE Kansas Hospital Region and the NW Missouri Hospital Region as appropriate. The hospitals in the NE Kansas and NW Missouri regions are illustrated in Appendix 3.

v. Incidents requiring the forward movement of patients will trigger the activation of local EOCs and may require the metro-area hospitals to initiate a Regional Healthcare Coordination System (RHCS) to assist in coordinating metro-wide hospital operations. If needed, the hospitals may also establish a Regional Healthcare Coordination Center (RHCC) to assist with hospital logistical requirements in support of forward movement operations.

vi. If activated during forward movement of patients operations, the RHCC will work closely with local EMS agencies, LPHAs/LHDs and EOCs to accomplish patient movement to hospitals reporting the capability to care for patients. For additional information on metro-area hospitals operations and the RHCS/RHCC, see Attachment C – Regional Healthcare Coordination Guide and Attachment J – Kansas City Regional Hospital and Healthcare Systems.

c. **Forward Movement to Other States**

i. If it is determined that the incident scope exceeds the capabilities of local and state resources, a request will be made by the affected local jurisdiction(s) to the appropriate State Emergency Management Agency (KEM and/or SEMA) for federal assistance through the National Disaster Medical System (NDMS).

ii. The Missouri and/or Kansas State Health Directors/Commissioners will be apprised of the situation and determine the need for NDMS activation. If needed, they will apprise the Governor of the need to request federal assistance. Under

some circumstances, the State Health Department Directors may request NDMS activation directly from the Secretary of Health.

iii. The NDMS is designed to care for victims of incidents exceeding the health and medical care capabilities of an affected state, region or federal medical care system. The NDMS may be activated for a variety of emergency events including natural disasters, a military contingency or an incident involving a CBRNE agent. NDMS hospitals nationwide are capable of accepting as many as 100,000 seriously ill or injured patients.

iv. The NDMS may be activated in one of three ways:

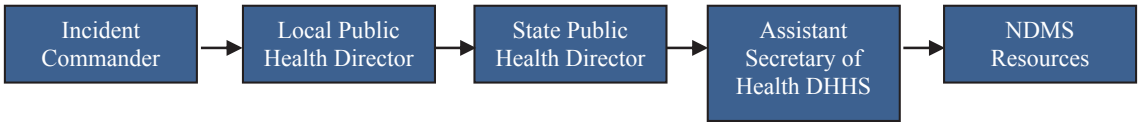
1. As illustrated in **Figure 1**, the State Governor with advice from local and state health officials may request federal assistance under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act. The Governor may request a Presidential declaration of a disaster or emergency through the FEMA Region VII Regional Director. A Presidential declaration will trigger a series of Federal responses including activation of the NDMS by the Assistant Secretary for Health, Department of Health and Human Services (HHS). In the event of a Presidential Declaration, cost for using the NDMS system will be borne by the federal government.

2. As illustrated in **Figure 2**, the State Health Department Director may request NDMS activation by contacting the Assistant Secretary of Health, Department of HHS, in situations where there is no Presidential disaster declaration. Such NDMS activations would take place under the authorities provided by the Public Health Service (PHS) Act. In this case, the requesting state will bear the costs of using the system unless a Presidential declaration follows.

3. Finally, if military casualty levels exceed or are expected to exceed the capability of the DOD/VA medical care systems, the Assistant Secretary of Defense can activate the NDMS.

Figure 1: Activation of NDMS – Presidential Disaster Declaration

Figure 2: Activation for NDMS – Public Health Service Act



v. There are three components to the NDMS
1. Patient movement from a disaster site to unaffected areas of the nation
2. Medical response to a disaster area in the form of teams, supplies, and equipment

3. Definitive medical care at participating hospitals in unaffected areas

4. **NDMS Operations**

a. Upon activation, the Kansas City Veterans Administration Medical Center (VAMC) will serve as the Kansas City Area Federal Coordinating Center (FCC). FCC responsibilities include coordinating the receipt and distribution of patients using policies and procedures developed in partnership with local, state and regional emergency response agencies and organizations.

b. The NDMS FCC will coordinate patient movement and work with other NDMS hospitals. The FCC is an integral part of the NDMS and will serve several functions in the forward movement of patients. Specifically, the VAMC FCC will:

i. Coordinate patient movement requests with the Global Patient Movement Requirements Center (GPMRC)

ii. Coordinate with NDMS member hospitals for the reception of patients

iii. Serve as the communications link with the GPMRC to request air transportation and relay information regarding the numbers and types of patients to be evacuated.

iv. Initiate and maintain communications with appropriate federal agencies

v. Coordinate the receipt of patients including the mobilization of medical resources for receiving, sorting, and transporting patients to designated hospitals.

c. Patients selected for ground evacuation shall be transported by all available ground assets (i.e., ambulances, as well as busses if necessary) to hospitals or alternate care sites outside of the region. If necessary, local EOCs in the affected areas will assist in arranging the transportation of patients to casualty collection points for ground movement outside of the area.

d. Patients selected for air evacuation will be transported from area hospitals and/or casualty collections points to NDMS air staging facilities established at the Charles B. Wheeler Downtown Airport in Kansas City, Missouri.

e. If the Charles B. Wheeler Downtown Airport is affected by the event or inaccessible for some reason, the Kansas City International Airport will be considered for NDMS flight operations. In extreme cases, other airports outside the region, such as Whiteman Air Force Base in Johnson County, Missouri, or Air Force facilities in Wichita, Kansas may be used. All NDMS flight operations support will be requested and coordinated by the FCC.

f. The State EOCs will coordinate with local EOCs in the region to determine if additional medical resources are needed to staff NDMS Air Staging Facilities at the selected airfield(s). If local systems are overwhelmed and personnel are not available, the state may request that NDMS Disaster Medical Assistance Teams (DMATS) serve this function.

g. Patient movement from area hospitals to the designated airfield(s) or casualty collection points will be coordinated by KCFD and other EMS agencies if necessary. If additional patient transportation resources are needed, they will be requested though local EOCs who

will coordinate other available transportation assets. For more information, see "Transportation".

h. The FCC will relay flight arrival times and flight capacities to KCFD Dispatch to coordinate patient ground movement to the airfield. A liaison at the air staging facility will be apprised of the number of patients being transported and flight arrival times. As appropriate, LPHAs/LHDs and EMS agencies will assist in transporting and providing care for patients awaiting transportation to other areas.

i. All NDMS operations will be conducted in accordance with the policies and procedures set forth in the Kansas City Metropolitan Area NDMS Plan. For information on local activities in support of NDMS patient reception operations, see Appendix 5.

5. **Transportation**

a. All available modes of transportation will be considered as needed to move patients out of the metropolitan area and to other parts of Missouri and Kansas or if necessary, to other parts of the nation.

b. Local EOPs include a Transportation Annex (or Emergency Support Function [ESF] #1) that will be used to activate and coordinate additional transportation resources needed in support of the event. In addition to EMS transportation resources (i.e., ambulances), local transportation assets include sizable fleets of wheelchair accessible buses and vans.

c. In addition to local government resources, most of the hospitals in the region maintain lists of available transportation assets for use in moving patients. The hospital transportation resource lists include helicopters maintained by several private air ambulance services.

d. State transportation assets for the forward movement of patients include those of the Missouri and Kansas Air National Guard which will be requested by local EOCs to their respective State EOC. Air guard resources include helicopter and fixed wing aircraft that may be used to transport patients. Federal air transportation assets for the forward movement of patients will be coordinated through the NDMS.

e. The transportation of patients via rail in the Kansas City metropolitan area is unlikely. However, the resources of AmTrak could be utilized for patient transport if no other ground assets were available. In this event, the AmTrak facilities at Union Station in Kansas City, Missouri may be used for patient staging and transport.

f. There are very few assets in the Kansas City metropolitan area suitable for transporting more than a few patients via water. In the unlikely event that patient transport needs to be accomplished using the two major waterways in the area (the Missouri and Kansas Rivers), the resources of the Missouri and Kansas Water Patrol and the Corps of Engineers would be requested.

6. **Coordination with EOCs**

a. To ensure the effective and efficient movement of patients using all available resources, it is critical that forward movement activities be coordinated with local EOCs. Local EOCs will serve as the hub for information management and resource allocation for the emergency event.

b. During forward movement of patients operations, local EOCs will:

   i. Request mutual aid and facilitate the declaration of a local emergency

   ii. Serve as the mechanism for coordinating requests for state and federal assistance

   iii. Coordinate transportation resources to move patients, equipment and/or supplies

   iv. Coordinate the activities of supporting local agencies, such as Public Health, Police and Fire

c. The LPHAs/LHDs in the affected jurisdictions will be active participants in local EOC operations and will serve as the local lead agency for Public Health and Medical Services operations. In some events, such as a Biological Incident, the LPHAs/LHDs may establish Departmental Operations Center specifically to coordinate health and medical activities.

d. Communications and coordination with local EOCs and if activated, LPHA/LHD Operations Centers, will occur via traditional methods (radio, telephone, facsimile), as well as through the Internet based capabilities of the EMSystem and WebEOC.

e. In major events, the MARC may serve as a Multi-Jurisdictional Coordination Entity at the request of local jurisdictions to assist with regional coordination issues.

D. Post-Incident (Recovery)

1. All involved agencies will continue coordination and communications with local EOCs, as well as established regional coordination centers, throughout the recovery phase.

2. As necessary, all supplies, equipment, PPE and pharmaceuticals will be inventoried and restocked.

3. All agencies will participate in after action briefings and evaluate the effectiveness of their emergency response. Based on lessons learned, involved agencies will conduct or participate in additional training and exercises to improve future response activities.

4. All involved agencies will work with the MARC to make necessary changes or enhancements to this Forward Movement of Patients Attachment.

5. Local governments will work closely with state and federal agencies to administer and coordinate assistance. In particular, ongoing coordination with the federal ESF #8 – Public Health and Medical Services group will be required.

6. Local governments will continue to coordinate with the VAMC FCC to monitor and support the NDMS elements of forward movement operations.

7. All involved agencies will continue to support forward movement operations as required by the event.

III. Responsibilities

Responsibilities for emergency operations are assigned in local EOPs and in the emergency plans maintained by the individual agencies and organizations involved in forward movement of patients operations. The responsibilities described below are not meant to be all inclusive, but rather to complement the responsibilities assigned in local plans and reinforce the activities described in this Attachment.

ORGANIZATION	RESPONSIBILITIES
ALL AGENCIES	➢ Participate in activities designed to improve coordination and communication during incidents involving the forward movement of patients including preparedness activities such as training and exercises
EMERGENCY MANAGEMENT AGENCIES	➢ Activate the EOC and implement the EOP in support of operations involving the forward movement of patients ➢ Provide transportation support for the movement of patients, equipment and supplies. ➢ Coordinate the activities of other local departments, agencies and volunteer organizations to support the forward movement of patients ➢ Coordinate with state emergency management agencies to ensure the timely request of state and federal assistance to support the forward movement of patients ➢ Continue coordination efforts with all involved agencies at the local, state and federal level.
LOCAL PUBLIC HEALTH AGENCIES/DEPARTMENTS	➢ Serve as the liaison between the hospitals and EMS agencies involved in the event and local government operations ➢ Monitor the EMSystem and WebEOC and provide appropriate input and feedback to hospitals and EMS agencies ➢ Maintain contact with the appropriate state agencies and ensure patients are appropriately tracked and identified to the state as requiring forward movement ➢ Provide information to and collect information from hospitals and healthcare agencies ➢ Serve as the lead agency in biological incidents.
EMERGENCY MEDICAL SERVICE (EMS) AGENCIES	➢ Work with hospitals and local EOCs to transport patients to definitive care facilities with the capacity to treat patients ➢ Track patients and provide this information to local EOCs through the EMSystem ➢ Assist in providing patient care at casualty collection points or patient transport staging areas ➢ Provide transportation for the movement of patients out of the region or state
HOSPITALS	➢ Implement hospital emergency plans, and establish a Hospital Incident Commander and a Hospital Incident Command Center ➢ Maintain communications with the appropriate LPHAs and local EOCs ➢ Coordinate with local EOCs for transportation and logistical support ➢ If practical and possible, participate as an NDMS hospital to support potential patients coming into the region from other affected areas
DHSS/KDHE	➢ Maintain contact with LPHAs/LHDs ➢ Activate state public health resources to assist local jurisdictions ➢ Provide technical assistance and guidance as required to LPHAs/LHDs ➢ Assist with the forward movement of patients outside the metropolitan area

VAMC/FCC	➢ When appropriate, implement the Kansas City Metropolitan NDMS Plan ➢ Work with local EOCs, hospitals and EMS agencies to coordinate the forward movement of patients ➢ Coordinate with other federal agencies to support NDMS operations

IV. Appendices

1. Patient Tracking System
2. Metropolitan Area Diversion Plan
3. Hospitals in the two regions (NE KS and NW MO)
4. Criteria for the Forward Movement of Patients
5. Local Support for NDMS Patient Reception Operations

Appendix 1: Patient Tracking System

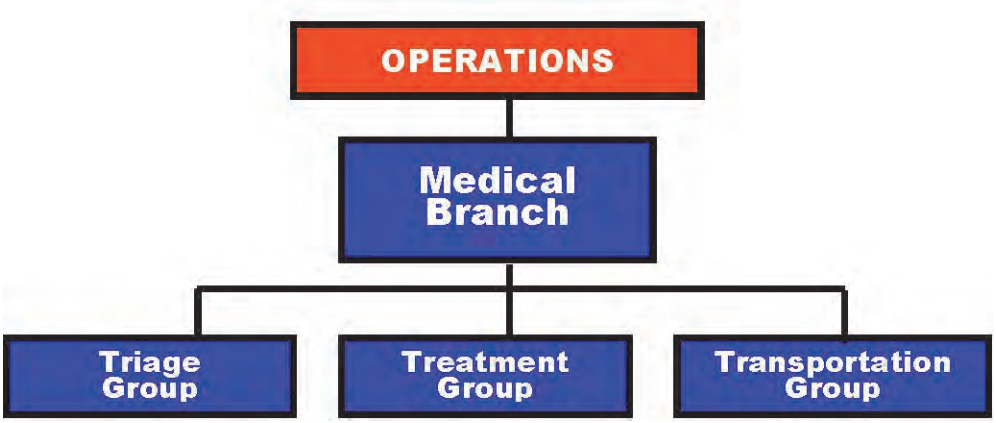
Patient Tracking System

- At this time, each organization has the responsibility to maintain accountability of patient movement through a manual process as identified by their respective organizational protocols and/or guidelines.

- As part of the on-scene triage process, patients are issued triage tags with a barcode that provides a color coded status as follows: red (immediate), yellow (delayed), green (minor), or black (morgue). The tags allow triage personnel to record specific patient information that becomes part of the patient record.

- When the scope of the incident requires it, the ICS structure using a triage, treatment and transportation groups under the Operations Branch as illustrated in **Figure 3** will be established to manage on-scene medical operations.

Figure 3: ICS – Triage, Treatment, and Transportation Groups



- Additional information and checklists for these positions may be found in the MARCER Mass Casualty Incident Plan.

Appendix 2: Metropolitan Area Hospitals and Catchment Areas

The Mid-America Regional Council Emergency Rescue Committee (MARCER) and the Health Alliance of Mid-America have developed a system of catchments for area hospitals.

Each hospital serves as the hub of its own area, and nearby hospitals (ideally within 15 minutes travel time or less) are the spokes. When a hospital is closed to ambulances and/or trauma patients, patients should be diverted to another hospital in that catchment area.

To access the most current list of hospitals, see:

- EMResource
- If you do not have access, contact the Mid-America Regional Council

Appendix 3: NW Missouri and NE Kansas Hospitals

To access the most current list of hospitals, see:

- EMResource
- If you do not have access, contact the Mid-America Regional Council

Appendix 4: Criteria for the Forward Movement of Patients

LEVEL	CRITERIA	ACTION	TAKEN BY
1* *Levels correspond to local EOC and LPHA/LHD activation levels	Primary receiving hospital(s) are nearing capacity or ability to treat specific injuries; or a single facility is overwhelmed and in need of evacuation	Reroute patients to metropolitan area hospitals reporting the capability to treat patients	On-Scene Transportation Officer
		Notify LPHAs/LHDs and EOCs if activated	Hospital Incident Commanders (ICs)
		Ensure the EMSystem is updated and issue an MCI Alert to other regional hospitals	Hospital IC(s)
		Notify Regional Healthcare Coordination System (RHCS)	Hospital IC(s)
2	Kansas City area hospital(s) are nearing capacity or ability to treat specific injuries	Coordinate with local EOCs and LPHAs/LHDs regarding resource needs and the potential need to support patient movement out of the Kansas City area	Hospital ICs (or the Hospital ICs may request that the RHCS established for the event perform this function)
		Notify other regional hospitals of potential need to reroute patients to their facilities	Hospital ICs (or RHCS)
		If not already activated, request activation of the Regional Healthcare Coordination Center (RHCC)	Hospital ICs (or RHCS)
		Ensure State EOCs are aware of the situation and the potential need to request activation of EMAC, NDMS and other appropriate state and federal resources to support hospital operations	Local EOCs (LPHAs will also work directly with state public health agencies)
3	Kansas City area hospital(s) have or will soon reach capacity or ability to treat specific injuries	Based on the lack of local hospital resources, authorize the forward movement of patients to hospitals outside the metropolitan area	Public Health Department Director(s) in coordination Hospital ICs and the RHCS
		* Request activation of the NDMS	Local EOCs
		* Request NE Kansas and NW Missouri regions to accept patients from the Kansas City area	RHCS
	Patients are moved outside the metro area	Provide transportation support (ground ambulances)	Local EMS Agencies
		Provide ground transportation support	Local government resources (if available and needed, local ground transportation resources may be augmented by National Guard resources)
		Provide medical support at casualty collection points	EMS Agencies and local hospitals
		Provide air ambulance resources	NDMS if activated and available, or State National Guard and private sector resources
		Coordinate with state and federal agencies	LPHAs/LHDs and EOCs
		Work with Hospital ICs to meet their resource needs	RHCS
		Work closely via the RHCS	Hospital ICs and local EOCs

** If available in a timely manner, the resources of the NDMS will be used for the forward movement of patients outside the metropolitan area. NDMS patient movement will be conducted using Federal resources in accordance with the activities described in the Forward Movement of Patients Attachment. If NDMS resources are unavailable, patients will be relocated to hospitals in Missouri and Kansas reporting the capacity to receive them by using local, state and private sector ground and air transportation resources.*

Appendix 5: Local Support for NDMA Patient Reception Operations

Overview

- In the event the Kansas City metropolitan area is designated as a reception site for NDMS patients from other parts of the nation, public health and medical resources in the Kansas City area will provide support as requested.

- Upon notification that patients will be arriving, the Kansas City area Federal Coordinating Center (FCC) at the Veterans Administration Medical Center (VAMC) in Kansas City, Missouri will assume responsibility for coordinating all actions associated with the management of patients received including the following:

    - Reception
    - Triage
    - Transportation
    - Hospitalization
    - Communications
    - Coordination
    - Patient Administration
    - Personnel Management

- The Kansas City FCC will coordinate with the appropriate local public health and medical agencies to ensure adequate personnel and resources are available for patient reception and transportation to NDMS hospitals.

- The FCC will coordinate with the Global Patient Movement Requirements Center (GPMRC) and relay information regarding the numbers and types of patients being transported to the Kansas City area.

- The FCC will provide liaison for all ongoing issues related to patient reception operations including reimbursements for transportation and hospital care.

Patient Reception Site (PRS)

- Due to its central location and flight receiving capabilities, the Patient Reception Site (PRS) has been designated at the Charles B. Wheeler Downtown Airport in Kansas City, Missouri.

- The FCC will work with the Kansas City Missouri Health Department (KCMO PHD), the Kansas City Fire Department (KCFD), Emergency Management, NDMS participating hospitals and the Charles B. Wheeler Airport to coordinate NDMS reception and transportation operations.

- The Joint Patient Reception Team (JPRT) will be comprised of management and medical staff from the Kansas City FCC, KCFD, as well as KCMO PHD and NDMS hospitals when deemed necessary. Team members must be prepared, equipped and dispatched to the PRS to receive, triage, regulate and transport casualties to the designated hospital.

- A basic planning assumption is that patients arriving at the PRS will be in stable medical condition. Appropriate treatment will be provided at the PRS if a patient's condition deteriorates during the flight.

- The JPRT will operate at the PRS using the Incident Command System (ICS). Coordination and control will be exercised through the Kansas City FCC and KCFD.

- The JPRT should be configured to receive and triage at least 50 casualties arriving on military aircraft. The JPRT Leader will serve as Incident Commander at the PRS. Operational, planning, administration and logistics support to the JPRT should include:

    - 1 Operations Section Chief (physician)
    - 1 Planning Section Chief
    - 1 Logistics Section Chief
    - 1 Admin Section Chief
    - 1 Public Affairs Officer
    - 1 Tracking Officer
    - 1 Regulating Officer
    - 2 TRANSAID input Operators
    - 1 Transportation Officer
    - 1 Staging Officer
    - 1 Communications Officer
    - 1 Contracting Officer
    - 1 Medical Supply Officer
    - 1 Pharmacy Officer
    - 2 Physicians (Section Leaders)
    - 4 RNs
    - 8 LPNs
    - 20 Litter Bearers (Coordinator and 5 four person teams)
    - Drivers with Vehicles
    - 1 Triage Team

- The composition of the JPRT may be modified based upon the number, categories and medical conditions of the incoming casualties. The JPRT Leader will coordinate staffing changes with Kansas City FCC.

- The JPRT will bring appropriate supplies and equipment with them to the PRS based upon preliminary patient information received from GPRMP.

- Based upon casualty information received from GPMRC, the Kansas City FCC and KCFD will coordinate the appropriate transportation to move patients quickly and safely from the PRS to the receiving hospital.

Triage Procedures Onboard Military Aircraft

- Prior to arrival of the aircraft, preliminary disposition of military patients will be made based upon initial patient information received from GPMRC. Upon arrival of the aircraft, the Operations Officer will coordinate with aircraft crew to expedite the triage and transfer of patients.

- The Triage Team(s) will board the aircraft, triage and determine appropriate disposition of the patients while still on board the aircraft. The Triage Team will confirm patient name, or other means of identification, with the aircraft passenger manifest prior to transporting patients from their location.

- After patients are off-loaded from the aircraft their personal information and medical condition will be processed. After being processed they will be medically regulated by the planning section to a receiving hospital. As soon as appropriate transportation is available the receiving hospital will be notified of patient's ETA and medical condition.

Triage Procedures Outside of Military Aircraft

- Prior to arrival of the aircraft, preliminary disposition of patients will be made based upon initial patient information received from GPMRC. Upon arrival of the aircraft, the Operations Officer will coordinate with aircraft crew to expedite off-loading of the patients and movement to a designated triage area.

- The Triage Team will triage and determine the appropriate disposition of the patients as quickly as possible. The Triage Team will confirm patient name or other means of identification with the aircraft passenger manifest prior to transporting patients from their location.

- After patients are off-loaded from the aircraft, their personal information and medical condition will be processed. After being processed, they will be medically regulated by the planning section to a receiving hospital. Once appropriate transportation is available, the receiving hospital will be notified of patient's ETA and medical condition.

NDMS Hospital Operations

- Upon receipt of an alert from the Kansas City FCC, participating hospitals may activate their hospital disaster plan (optional) and prepare to confirm availability of beds and services. Confirmation of beds and services will be required only when it can be determined, with some degree of certainty, that they will be needed with 24-72 hours.

- NDMS hospitals will report the availability of beds to the FCC by fax based on a fax number will be provided upon activation. The initial report is to be submitted no later than 4 hours after notification.

- The Kansas City FCC will be notified to report participating NDMS hospital bed availability to the GPMRC. Patients will be regulated to NDMS areas using the five bed availability categories as follows:

    - Medical-Surgical (MM-SS)
    - Critical Care (CC)
    - Psychiatry (MP)
    - Pediatrics (MC)
    - Burns (SBN)

- NDMS hospitals should make available the maximum number of staffed operating beds in the five designated categories for the reception of patients in accordance with priorities of care.

- Receiving hospitals will assist with the reception and transportation of patients from the PRS when requested. Following the receipt and admission of patients, participating hospitals will prepare an NDMS Admission and Disposition Summary indicating the expected length of stay.

- NDMS hospitals will submit the following information to the Kansas City Area FCC daily:

    - Daily Bed Report Summary
    - Daily Admissions and Disposition List (indicating the expected length of stay
    - NDMS Admission Summary (after the receipt and admission of each patient)

- After admission, the medical staff of the participating hospital will accomplish the patient's day-to-day medical management and care.

Bed Availability Reporting

- Upon activation of the NDMS, the FCC will begin coordination of bed availability reporting by contacting the KCFD Dispatcher and requesting a bed availability report. KCFD will notify hospitals via the EMSystem and will report the numbers to the FCC.

- Based upon collective bed availability data, the FCC and KCFD will identify the potential number of patients expected and assess available transportation requirements.

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KANSAS CITY REGION

ESF 8 ATTACHMENT J

ATTACHMENT J:

Kansas City Regional Hospital and Healthcare Systems

ATTACHMENT J. KANSAS CITY REGIONAL HOSPITAL AND HEALTHCARE SYSTEMS PLAN

I. Overview

Purpose and Scope

1. This Attachment has been developed to coordinate and augment the emergency capabilities of metropolitan area hospitals in the event of a mass casualty or Chemical, Biological, Radiological, Nuclear or Explosive (CBRNE) incident.

2. Specifically, this Attachment:

   a. Addresses how hospitals and healthcare facilities will be notified of a mass casualty event

   b. Identifies how hospitals and healthcare facilities will call up additional medical staff

   c. Discusses Emergency Medical Services (EMS) – Hospital coordination requirements during mass casualty incidents

   d. Describes the mechanisms used to improve coordination between the hospitals and local Public Health Agencies/Departments (LPHAs/LHDs), Emergency Management Agencies (EMAs) and EMS agencies in the region

   e. Addresses the ability of medical staff to recognize, triage and treat victims

   f. Identifies procedures for the treatment and management of patients arriving at hospitals without prior decontamination

   g. Describes hospital and health care facility plans for protection from environmental and/or patient source contamination

   h. Identifies readily available treatment protocols for a CBRNE incident

i. Describes coordination with the local Emergency Operations Plan (EOP) and the local Emergency Operations Center (EOC)

j. Identifies the ability to ensure a surge capacity to accommodate critically ill patients in hospitals or alternative health care facilities

k. Addresses security procedures at hospitals and health care facilities

l. Identifies necessary personal protective equipment for hospital staff and available pharmaceuticals

m. Identifies locally-available pharmaceuticals and equipment, and establishes procedure for obtaining additional supplies in a timely manner

3. This Attachment has been developed for all of the hospitals and healthcare facilities in the nine (9) county Kansas City Metropolitan area represented by the Mid-America Regional Council (MARC).

4. This Attachment is designed to integrate with and complement the existing hospital and healthcare facility emergency plans and procedures in place throughout the metropolitan area – for more information, see "Background".

5. This Attachment is designed to be flexible and the extent of its activation will be determined by the nature and scope of the mass casualty or CBRNE incident.

6. This Attachment is one of several components that make up ESF 8. To the extent possible, information contained in other plan components will be referenced, not repeated in this document.

Background

1. The Kansas City metro-area is fortunate to be served by nearly thirty (30) local hospitals.

2. The metro-area hospitals deal with emergency situations on a regular basis and although the hospitals have capabilities and resources for response to most emergency events, a mass casualty incident or CBRNE event has the ability to tax or exceed the regional hospital and healthcare system.

3. The hospitals in the nine (9) county area maintain emergency plans as required by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). These plans detail the performance of emergency activities in response to a mass casualty or CBRNE event and are referenced as appropriate throughout this Attachment.

4. As described under "Coordination", the hospitals and healthcare systems in the region work together on a regular basis and participate in planning and preparedness activities to strengthen the region's hospital capabilities.

II. Emergency Activities

A. General

1. The Hospitals and Healthcare Systems Attachment is not designed to be operational, but rather to address the necessary coordination elements required to efficiently and effectively manage the human health consequences of a mass fatalities or CBRNE incident affecting the metro-area.

2. The activities of the hospitals and healthcare facilities in the region will be carried out in accordance with their internal emergency plans and procedures, and coordinated with the local Emergency Operations Plans (EOPs) and public health related emergency response plans in their respective jurisdictions.

B. Pre-Incident (Prevention and Preparedness)

Capabilities

- Capabilities assessments have been conducted by hospitals in both the northeast Kansas Region and Region A in northwest Missouri. These assessments describe the needs identified by the hospitals, which include training and special equipment.

- A capabilities assessment conducted for all of the emergency services organizations in the nine (9) county MARC region is maintained by the Regional Homeland Security Coordinating Committee (RHSCC).

Coordination

- The RHSCC serves as the Steering Committee and provides oversight for homeland security issues in the region. The RHSCC Hospital Subcommittee is one of several subcommittees with assigned tasks and members representative of the special subject matter expertise required to accomplish them.

- The RHSCC Hospital Subcommittee meets on a regular basis to address hospital related operational and coordination issues. RHSCC Hospital Subcommittee members include representation from local hospitals and healthcare agencies throughout the metropolitan area. Important regional preparedness initiatives undertaken by the RHSCC Hospital Subcommittee include:

  i. Developing a Disaster Medical Assistance Team (DMAT) in the region

  ii. Supporting additional regional hospital communications capabilities

  iii. Procuring hospital trailers and equipment to assist with CBRNE and mass casualty incidents, and maintaining Tier I hospital equipment capabilities

  iv. Participating in regional exercises with Public Health, Emergency Management, EMS, Fire Services and other agencies to test various CBRNE response capabilities

v. Supporting ongoing hospital preparedness initiatives to meet JCAHO standards (such as training and exercises) related to CBRNE or mass casualty events

vi. Participating in other regional initiatives, such as MEDS/POD (a mass prophylaxis dispensing system) and others

- The activities described in here are coordinated with the state and federal agencies responsible for providing guidance and technical assistance with hospital preparedness activities. The Kansas Department of Health and Environment (KDHE) and the Missouri Department of Health and Senior Services (DHSS) provide guidance from the state level; while the Centers for Disease Control (CDC) and the Department of Health and Human Services (HHS) provide primary federal guidance and technical assistance. The information included in this Attachment is consistent with guidance provided by these state and federal agencies.

- Another regional coordination mechanism, the Missouri and Kansas Hospital Associations, facilitates both local and regional hospital planning activities in their respective states. The Hospital and Healthcare Systems Attachment has also been coordinated with the MARC Emergency Rescue Committee (MARCER), the Metropolitan Official Health Agencies of the Kansas City Area (MOHAKCA) and the Regional Emergency Nurse Managers Association.

- For additional information on regional coordination activities and preparedness organizations, see the RCG: Base Guide.

Other Plans

1. As described under "Background," this Attachment is designed to complement and augment the emergency plans and procedures maintained by the individual hospitals and healthcare facilities in the region. Where appropriate, portions of the plans, procedures and guidelines described below have been integrated and referenced as appropriate in this Attachment.

2. This Attachment is coordinated with the MARCER Mass Casualty Incident (MCI) Plan, the EMSystem Policies and Protocols Manual, the Metropolitan Community Plan for Diversion and the National Disaster Medical System (NDMS) Plan for the region.

3. This Attachment is coordinated with the local Emergency Operations Plans (EOPs) and local public health related emergency response plans maintained by the individual jurisdictions in the region. The hospitals work with local Emergency Management Agencies (EMAs) and LPHAs/LHDs on a regular basis to strengthen planning and preparedness for a mass casualty or CBRNE event.

4. This Attachment is coordinated with the MARC Medical Reserve Corps Plan, which details the use of volunteer medical professionals to augment existing health and medical capabilities. For additional information, see the Regional Coordination Guide.

Mutual Aid

- A Memorandum of Understanding (MOU) between the hospitals in the region is included in Attachment O: Healthcare Related MOUs.

- A Memorandum of Agreement (MOA) is maintained between several hospitals in the metro-area and the Veteran's Administration Medical Center (VAMC), which serves as the regional Federal Coordination Center (FCC) for the National Disaster Medical System (NDMS).

- A sample of the NDMS MOA is included as Appendix 3. Hospitals in the metropolitan area are encouraged to participate in NDMS by signing the MOA. For additional information on NDMS, see Attachment I – Forward Movement of Patients.

Training and Exercises

- Additional preparedness initiatives by the hospitals in the region include joint training and exercises. The RHSCC Training and Exercise Subcommittee sponsors regular training and exercises that include participation by the hospitals and healthcare systems in the region. Without such ongoing preparedness activities, hospital personnel turnover would reduce hospital readiness.

- The training and exercises recommended for hospital personnel must be relevant, easy to conduct, streamlined to complement the medical backgrounds of hospital responders and to the extent possible, integrated into existing training and exercise programs. High-maintenance preparedness systems may only add a burden to hospitals and lower the probability that readiness will be maintained.

- With this in mind, training and exercise scenarios related to health and medical activities will be integrated to the extent possible into the training and exercises required by JCAHO. The prevention and readiness initiatives established by the JCAHO and the Occupational Health and Safety Administration (OSHA) will be adhered to by the hospitals and healthcare organizations in the region.

- Mass casualty and CBRNE training courses for hospital personnel are offered through several sources including the Federal Emergency Management Agency (FEMA), Office of Grants and Training (G & T) and the Centers for Disease Control (CDC). Core competencies for hospital personnel have been established, and are included in the Emergency Responder Training Guidelines recommended by G & T and adapted for use by MARC.

- Exercises will be conducted to test the ability of hospitals and their staff to:

    - Properly use PPE and other special response equipment
    - Implement decontamination plans and procedures
    - Call-up additional emergency staff
    - Implement the Hospital Emergency Incident Command System (HEICS)
    - Practice using standardized reporting for mass casualty incidents
    - Accomplish hospital evacuation, relocation and re-entry
    - Implement the Regional Healthcare Coordination System as described under "Incident Management"

- Practice surge capacity to accommodate large numbers of patients as described under "Augmentation of Hospital Facilities."

- Implement isolation and quarantine plans

C. Incident (Response)

Notification and Communications

1. **Notification**

Mass Casualty Incident (MCI) Alert

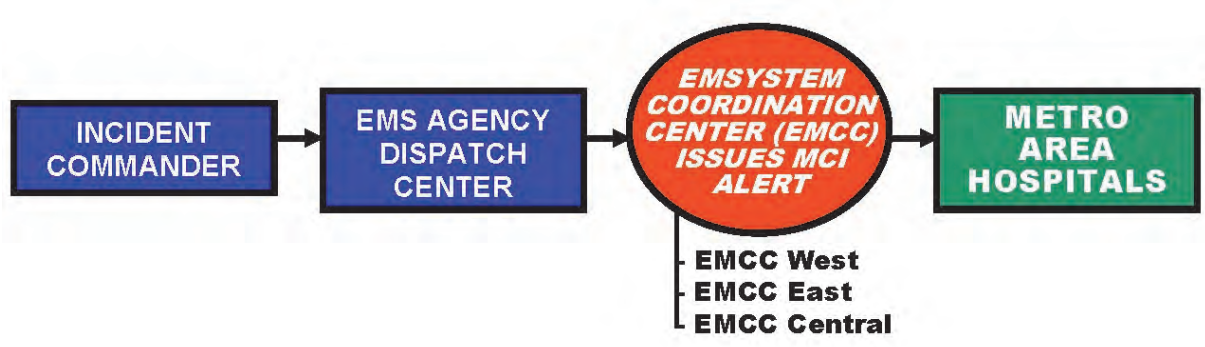
- In the event of a mass casualty incident, the Incident Commander (IC) will contact the appropriate EMSystem Coordination Center (EMCC) through their agency dispatch center and request that a Mass Casualty Alert (MCI) be issued through the EMSystem (see Figure 1). The MCI Alert may be local in nature (i.e., issued to the five hospitals closest to the incident) or it can be issued to all hospitals metropolitan-wide.

- The EMSystem is a web-based program providing real-time information on hospital emergency department status, patient capacity, and the availability of staffed beds and specialized treatment capabilities. The EMSystem is used in the metropolitan area to link all acute-care hospitals and most EMS agencies.

- The three (3) EMSystem Coordination Centers (EMCC) are:

  - EMCC West: Johnson County Emergency Communications Center
  - EMCC Central: Kansas City Fire Department (KCFD)
  - EMCC East: Lee's Summit Fire Department

Figure 1: Notification from IC to Hospitals through the EMSystem



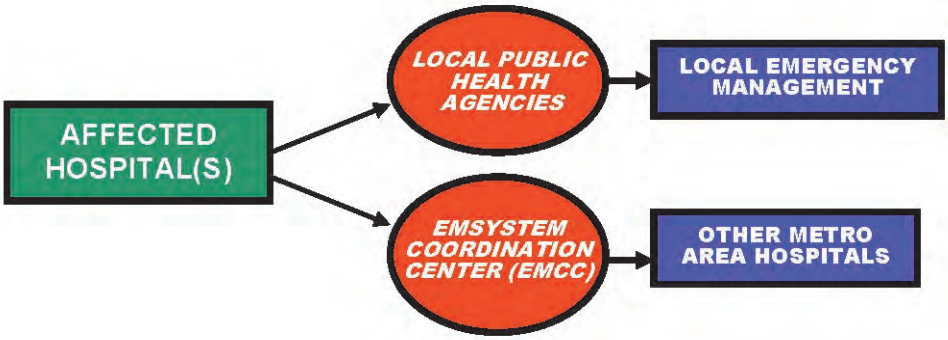
- For additional information on MCI Alerts and the EMSystem, see the EMSystem Policies and Protocols Manual and the MARCER MCI Plan.

Other Notifications

- Hospitals may be notified of a potential public health emergency or biological incident through the capabilities of the Health Alert Network (HAN). The Kansas and Missouri HANs are capable of notifying hospitals, LPHAs/LHDs, Emergency Management and other local agencies and health care providers of a public health emergency. Notification to hospitals may also come from LPHAs/LHDs simply via telephone, e-mail and fax.

- In some events, hospitals may be the first to identify a mass casualty or CBRNE incident through the presentation of walk-in patients. In this scenario as illustrated in Figure 2, the affected hospital(s) will notify the EMSystem Coordination Center (EMCC), as well as the LPHAs/LHDs in the affected jurisdictions. LPHAs/LHDs will alert the Emergency Management Agencies (EMAs) and other appropriate officials in their jurisdictions.

Figure 2: Notification from Hospitals to Local Agencies of a Mass Casualty Event



- Upon notification or recognition of an event, hospitals will activate their disaster response plans and notify staff. The metro-area hospitals maintain their own dispatching and alerting capabilities, and will notify and call-up personnel via their internal procedures.

2. **Communications**

- In addition to the EMSystem, communications between hospitals and EMS agencies will occur through the Medical Channel System (Med Channel), a two- way communication system allowing EMS responders from over thirty (30) agencies to communicate with area hospitals regarding pre-hospital patient care and to alert hospitals to in-coming patient situations. The 800 megahertz VHF radio system provides additional radio communications capabilities throughout the metro-area.

- The Hospital Emergency Administrative Radio (HEAR) system is also available to link hospitals and many area EMS agencies on a single radio channel. The HEAR serves as a backup to the EMSystem and may be accessed by contacting the Primary Control Hospital, who will alert other hospitals of the incident.

- As illustrated in Figure 3, the on-scene Medical Transportation Officer will keep the EMCCs and/or the responding agency's dispatch center informed of the nature and scope of the incident including but not limited to the location, known CBRNE substances and the estimated number of affected persons.

Figure 3: Field Communication with Hospitals during a Mass Casualty Event

- EMS agencies both on scene and in route will maintain close contact with the hospitals regarding potential dangers to hospital personnel from a CBRNE agent. EMS agencies will provide hospitals with information regarding the CBRNE substance involved so that if necessary, they may begin preparing to implement their decontamination procedures.

- The EMCCs and local dispatch agencies will be notified in the event the Regional Healthcare Coordination Center (RHCC) is activated and begin relaying pertinent EMS information to the RHCC.

- Hospitals will communicate with each other using traditional methods (i.e., telephone and facsimile), as well as the capabilities of the EMSystem and if necessary the HEAR system. Hospitals will notify other healthcare facilities and physicians of a mass casualty or CBRNE event through the capabilities of HAN.

Patient Management and Tracking

a. **General**

- Managing a significant number of patients involved in a large-scale incident will require the rapid identification, assessment, collection and communication of patient conditions and locations between hospitals and EMS agencies.

- Patients will be routed to hospitals throughout the metro-area as necessary by the On-site Medical Transportation Officer, based on treatment capability information provided by the hospitals through the EMSystem. As appropriate, patients with significant trauma will be routed to a trauma center reporting a capability to treat the patients.

- Information regarding the need to transfer patients from one hospital to another will be relayed through the HEICS/HICS structure to the EMCC, which will assist in coordinating patient transfers between facilities. Patient identification will be logged when exiting the hospital and confirmed at the receiving hospital intake point. All patient transfers will follow current Emergency Medical Treatment and Labor Act (EMTALA) and Hospital Information Portability Protection Act (HIPPA) procedures.

- When activated, the Regional Healthcare Coordination System (RHCS) and the Regional Healthcare Coordination Center (RHCC) may assist hospitals and EMS agencies with patient routing and distribution.

b. **Patient Tracking System**

- At this time, each organization has the responsibility to maintain accountability of patient movement through a manual process as identified by their respective organizational protocols and/or guidelines.

Incident Management

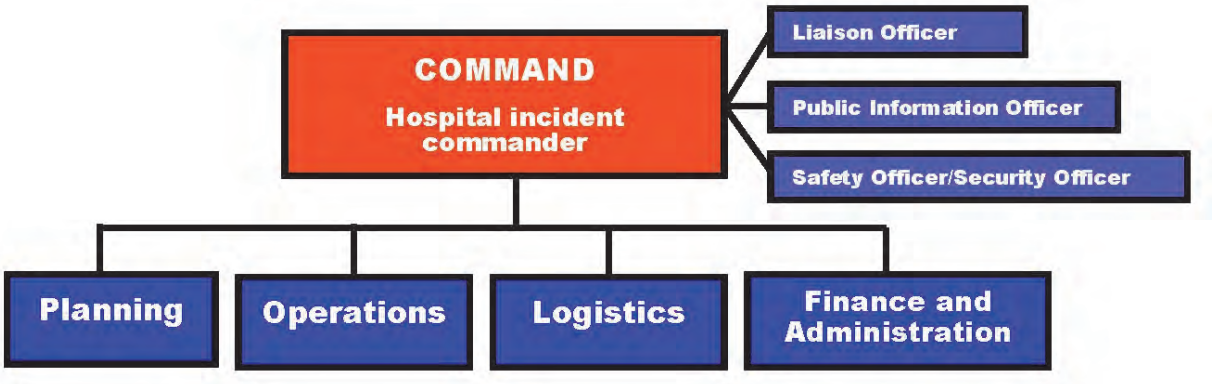
a. **Hospital Incident Command**

- The National Incident Management System (NIMS) and the Incident Command System (ICS) will be used to manage emergency incidents in the Kansas City metropolitan area. The Hospital Emergency Incident Command System (HEICS/HICS) will be used by the hospitals in the region to manage emergency incidents.

- The HEICS/HICS is designed to provide a logical structure, defined responsibilities, clear lines of command and common terminology to assist hospitals in managing emergency events. The use of a common command structure will assist with coordination during events and allow medical personnel to easily integrate with the command structure in any hospital facility.

- Both ICS and HEICS/HICS follow the standard organization format illustrated in Figure 4.

Figure 4: ICS and HEICS/HICS Organization



- The functions of the ICS and HEICS/HICS sections are briefly described below.

1. Command

   a. Maintain overall leadership and coordination for the event

   b. Provide the authority to allocate hospital resources

   c. Designate support staff to Operations, Planning, Logistics and Finance and Administration functions

2. Operations

    a. Perform emergency activities to reduce immediate hazards

    b. Establish control of the incident and restore normal conditions

    c. Support operational needs and requests for resources

    d. Identify resources to support operational activities

3. Planning

    a. Maintain information on the situation and the status of needed and available resources

    b. Develop a hospital Incident Action Plan (IAP) to describe objectives, strategy, organization, and the resources necessary to effectively manage the incident

    c. Maintain the status of all assigned resources at the incident

    d. Collect, process, and organize incident information

    e. Maintain accurate incident files

    f. Develop the incident demobilization plan

4. Logistics

    a. Provide support with the identification and acquisition of additional resources, such as:

        i. Specialized equipment and/or trained personnel

        ii. Facilities and special transportation

        iii. Additional or specialized supplies and/or equipment

        iv. Fuel, fuel and communications

        v. Other needs as dictated by the event

5. Finance

    a. Develop financial and cost analyses for the event

    b. Manage complex administrative matters

    c. Identify and evaluate of contracts or agreements

    d. Fulfill the documentation requirements of the event

b. **Regional Healthcare Coordination System (RHCS)**

- Purpose

1. In the event of a major incident affecting several hospitals in the metropolitan area, the Regional Healthcare Coordination System (RHCS) may be established to assist the affected healthcare facilities and facilitate the exchange of information regarding hospitals operations. See ESF 8: Concept of Operations and Attachment C: Regional Healthcare Coordination Guide.

2. The primary purpose of the RHCS will be to:

   a. Establish as a mechanism for collecting and disseminating information regarding the requirements for, and availability of, hospital resources including, but not limited to the following:

      i. Equipment

      ii. Supplies

      iii. Bed capacities

      iv. Personnel

      v. Special treatment capabilities

   b. Facilitate the sharing of resources and personnel among hospitals in the region.

   c. Ensure a unified and coordinated incident management approach among the responding hospitals.

   d. Provide a structure for hospitals to communicate and coordinate among themselves.

   e. Coordinate resources and personnel from hospitals outside the region.

   f. Provide a means for centralized coordination with local, state and federal emergency services organizations.

c. **Coordination with the States**

i. Both Missouri and Kansas have established hospital regions as follows: Missouri Region A comprised of thirteen (13) counties in northwest Missouri; and the Northeast (NE) Kansas Region comprised of thirty (34) counties in NE Kansas.

ii. The NE Kansas Regional Hospital Plan may be activated when more than two hospitals in the region are responding to an emergency, and resources to respond to the event may be exhausted. Activation of the plan authorizes the deployment of available resources such as personnel, supplies, equipment and facilities. The Regional Hospital Plan for the NE Kansas Region also establishes a Regional Hospital Command Center in Topeka, Kansas.

iii. The affected Missouri hospitals will coordinate with LPHAs and DHSS and LPHAs to implement the provisions of the Missouri Region A Hospital Plan in support of metro-area activities. Support from Region A may come in the form of resources, personnel, supplies, equipment and facilities.

iv. The metro-area RHCS and the RHCC, when activated, will maintain communications as appropriate with the NE Kansas Hospital Command Center in Topeka, as well as with any state or regional hospital command centers established by Missouri DHHS.

v. Particularly, close coordination between the RHCS and the hospitals in Missouri Region A and the NE Kansas Region will be required in the event the need arises to move patients outside the metropolitan area and into hospitals located in one or both of these regions. For more information, see Attachment I – Forward Movement of Patients.

Triage

- The metro-area hospitals will triage patients using standard triage principles, as triage is a task hospitals perform daily. Hospitals maintain standard operating procedures for triage and any specialized triage procedures indicated by CBRNE treatment protocols referenced above will be incorporated as appropriate.

- When the number of patients arriving without EMS transport is large, the hospitals may establish a triage area. The triage system may include using the triage tags, which are color coded and identify patients as:

  - **RED - First priority in patient care, these are victims in critical condition whose survival depends upon immediate care. Treatment of red victims should begin as soon as possible.**

  - **YELLOW - Victims that need urgent medical attention and are likely to survive if simple care is given as soon as possible.**

  - **GREEN - Victims who require only simple care or observation. Even though victims in this category may appear uninjured and emotionally stable, they must be evacuated to a medical facility for evaluation by trained medical personnel.**

  - **BLACK - These victims are dead or whose injuries make them unlikely to survive and/or extensive or complicated care is needed within minutes.**

- If the scope of the incident is large, triage during mass casualty incidents, may be performed to accomplish the greatest good for the greatest number of casualties. In this case, an "expectant" category may be used for those who are hopelessly wounded/ill, or in cardiac arrest on initial evaluation. The use of limited resources to treat such patients could jeopardize the ability of other less seriously ill of injured patients.

- The need to establish an expectant category will be dependent on resources available. Since triaging patients as 'expectant' is seldom done, proper training and exercises will be needed to practice triage procedures for a mass casualty incident with expectant patients.

- The triage and initial care of contaminated patients presents special concerns for hospital personnel and recommendations for appropriate PPE for hospital staff will be made by the Safety Officer as dictated by the event. Hospital personnel should be familiar with performing triage and administering treatment while wearing PPE.

- The triage of patients when establishing surge hospitals and/or Alternate Care Sites as described under "Surge Capacity" will be accomplished to the extent possible using the capabilities of the patient tracking system and the principles of START.

Treatment

a. **General**

- Metro-area hospitals have access to emergency treatment protocols for CBRNE illnesses and injuries through several Internet sites and 24-hour emergency assistance numbers such as those maintained by the Centers for Disease Control (CDC); National Institute for Occupational Safety and Health (NIOSH); the Poison Control Center; TOMES Medical and Pharmaceutical Services; and the Radiation Emergency Assistance Center (REAC) Training Site.

- Metro-area hospitals also have access to CBRNE treatment protocols in hard copy (e.g., Jane's Chem-Bio Handbook). However, the most current treatment protocols for CBRNE substances are normally available on the Internet and may be downloaded and printed when needed.

b. **Decontamination**

- As much decontamination as possible should be performed prior to the transport of patients to definitive care facilities. However, if contaminated patients arrive at hospitals, appropriate decontamination will be performed based on the agent involved.

- As described under "Communications," the on-site Transportation Officer and EMS agencies in route will provide receiving hospitals with as much information as possible on patients requiring decontamination.

- Once notified of an incident with the potential need for patient decontamination, hospitals will prepare to implement their decontamination procedures. The hospitals in the metropolitan area have Tier I decontamination capabilities.

- Hospitals will use their own decontamination equipment first and if additional equipment is required, the hospital will request use of decontamination equipment from nearby hospitals. If equipment is still needed, the hospital may contact other hospitals in the region, or request activation of the local EOC (if not already activated) and the RHCS.

- Clinics and others without decontamination capabilities will secure their facilities according to internal procedures and refer patients to hospitals or if necessary, casualty collection points that can perform decontamination.

- The EMSystem will be used by hospitals to inform EMS agencies of hospital decontamination and treatment capabilities. Any hospital reaching its capacity to decontaminate and/or treat patients will inform the EMSystem Coordination Center (EMCC) and additional patients to be routed to other facilities.

- Depending on the nature and scope of the incident, situations may arise where large numbers of patients awaiting decontamination present a threat to the safety of hospital personnel. If additional security is unavailable and there is a threat of contaminating hospital staff, personnel should retreat to the safety of the hospital.

- Hospitals institute restricted access (i.e., "lock down") procedures, if contaminated individuals present a threat to hospital personnel. Restricted access procedures are described in hospital emergency plans and should be tested on a regular basis. For additional information, see "Security".

c. **Isolation and Quarantine**

- According to Kansas and Missouri statutes, local Public Health Directors have legal responsibility for ordering isolation or quarantine. Local Public Health Directors will provide guidance to hospitals on the need for the isolation of symptomatic ill persons and the quarantine of exposed persons who are not yet ill.

- Public Health Directors and LPHAs/LHDs will work closely with Hospital ICs to ensure appropriate isolation and quarantine information is available to hospitals in a timely manner. Based on this information and/or current CDC guidance, hospitals will implement appropriate isolation and/or quarantine procedures per their Infection Control Policy Manuals, which direct internal isolation and quarantine procedures.

- In the event that the number of patients requiring isolation or quarantine exceeds hospital capabilities, consideration will be given to co-locating several patients to a room. Further, based on the agent involved and the number of people affected, consideration may be given to having one or more hospitals serve as the primary isolation and/or quarantine facilities for the event.

- LPHAs/LHDs will develop public information messages informing citizens of public health decisions regarding isolation and/or quarantine. Each jurisdiction will provide specific instructions to its residents through the local EOC and JIC.

- In the event that exposed or ill persons are unwilling to comply voluntarily with isolation or quarantine procedures, hospitals may contact local law enforcement for assistance. Local law enforcement in consultation with LPHAs/LHDs will be responsible for implementing measures to ensure quarantine and isolation orders are observed to the extent permitted by law.

Surge Capacity

a. **General**

- Each hospital will manage an increased number of patients in-house to the extent possible. The affected hospital(s) will implement the HEICS/HICS, activate their Command Centers and initiate internal plans to increase bed capacity. Such plans may include procedures to discharge all patients who can safely be sent home and cancel all non-critical and elective surgeries.

- If one or more hospitals become overburdened, other hospitals in the region may activate their Command Centers to provide support and prepare for the potential receipt of patients. Additionally, as described under "Incident Management," the RHCS may be activated to support and coordinate patient surge operations.

- Metro-area hospitals have identified the approximate number of beds available for surge capacity. It is estimated that the hospitals in the nine (9) county region have a nine hundred sixty (960) total bed reserve capacity for inpatients on any given day. EMS agencies and hospitals will utilize the EMSystem at the time of the incident to determine immediate bed availability, and to coordinate the transportation of patients to hospitals with the ability to accept and treat them.

- If necessary, metro-area hospitals may expand their bed capacities by adding additional beds to existing rooms and other hospital areas in which to cohort patients. Some of the hospitals in the region have cots on hand to further expand room capacities in extreme emergencies. In addition, the nine (9) mobile trailers maintained by the hospitals in the region have the capability to provide cots and supplies for nine hundred thirty (930) patients. The Mass Casualty Incident (MCI) trailers maintained by EMS agencies also provide an additional source of supplies for hospitals expanding their normal bed capacities.

- If all beds in the region are at capacity, hospitals will transfer patients to hospitals in other regions and/or activate the resources of the National Disaster Medical System (NDMS) as described in Attachment I – Forward Movement of Patients. If hospitals in other regions are full and the forward movement of patients is not practical or feasible, acute care may be provided at alternate locations as described below under "Augmentation of Hospital Facilities."

b. **Augmentation of Hospital Facilities**

- Hospitals may increase bed capacities by transferring non-critical or ambulatory patients to Ambulatory Surgery Centers (ASC's); Federally Qualified Health Clinics (FQHCs); and/or other long-term health care facilities capable of providing extended patient care (such as nursing home and residential care facilities outside the disaster area). Such transfers will allow hospitals to focus on inpatient care, while ambulatory or minimal patients receive care at other facilities.

- ASCs are capable of suturing, casting and minor assessments, and may be a valuable resource for balancing the overflow of patients in the event of a significant disaster in the metro-area. Representatives from a number of ASCs are on the RHSCC Hospital Subcommittee and have been active in identifying ways ASCs might be used emergencies.

- In addition to ASCs, Community Health Centers (Federally Qualified Health Centers) may also be used as secondary treatment facilities. There are two (2) FQHCs in Kansas City, Missouri and if needed, hospitals will work the Kansas City Missouri Health Department to access these resources. A list of the ASCs and FQHCs is found in Appendix 5.

- An additional resource potentially available to assist with the augmentation of hospitals in the metro-area is the Expeditionary Medical Support (EMEDS) system, a modular mobile field hospital available through the Kansas National Guard. Requests for state resources will be made as described under "Coordination with Local Governments."

c. **Alternate Care Sites**

- To manage very large numbers of patients, hospitals may coordinate the establishment of Alternate Care Sites (ACSs) at facilities capable of expansion to provide patient care during major medical emergencies. If needed, community centers, schools and colleges, large businesses, churches, auditoriums and other facilities may be established as ACSs.

- Addendum A to Appendix 1 identifies current on-site and off-site hospital expansion capabilities.

- Since there are a limited number facilities suitable for use as ACSs in the metro-area, many of the hospitals plan to initiate work with local EMAs to identify facilities appropriate for use as ACSs. The capabilities of the Mass Care or Sheltering annexes of local EOPs may be used as starting points for identifying facilities suitable for use as ACSs. As ACS sites are identified and plans developed, the information will be added to hospital plans and other local and regional plans as appropriate.

- Hospitals will staff ACSs to the extent possible by recalling all available personnel. Staff may be augmented by personnel from unaffected hospitals in the area, hospitals outside the region, the resources of the NDMS and by members of the Regional Medical Reserve Corps (MRC).

- Metro-area hospitals may also seek volunteers from medical, nursing and other healthcare institutions to provide assistance in extreme emergencies. In addition, the Modular Emergency Medical System (MEMS) as described below provides a model for determining the number of staff needed for operation of ACSs, as well as suggestions for augmenting medical staff in emergencies.

- It is recognized that maintaining normal standards of hospital care in surge hospitals and ACSs may be difficult, if not impossible. With this in mind, medical treatment in such facilities may reach only "sufficiency of care" standards.

- Sufficiency of care during extreme emergency events may not be the same as that delivered under non-emergency circumstances, but the quality of care provided is sufficient for the need based on the resources available (e.g., the implementation of limited privacy, minimum testing, elevation of responsibility for health care workers, etc.). Sufficiency of care will be provided in accordance with JCAHO and the Agency for Research and Health Quality (AHRQ) guidance.

- When operating a sufficiency of care facility, patients will be treated to the extent possible and transferred to a facility with full treatment capabilities when available.

- Metro-area hospitals will work closely with state and local public health officials to determine appropriate sufficiency of care standards when establishing surge hospitals and/or ACSs. When necessary, the decision to alter standards of care should be made consistently by all hospitals in the metro- area with guidance and assistance from LPHAs/LHDs and the state.

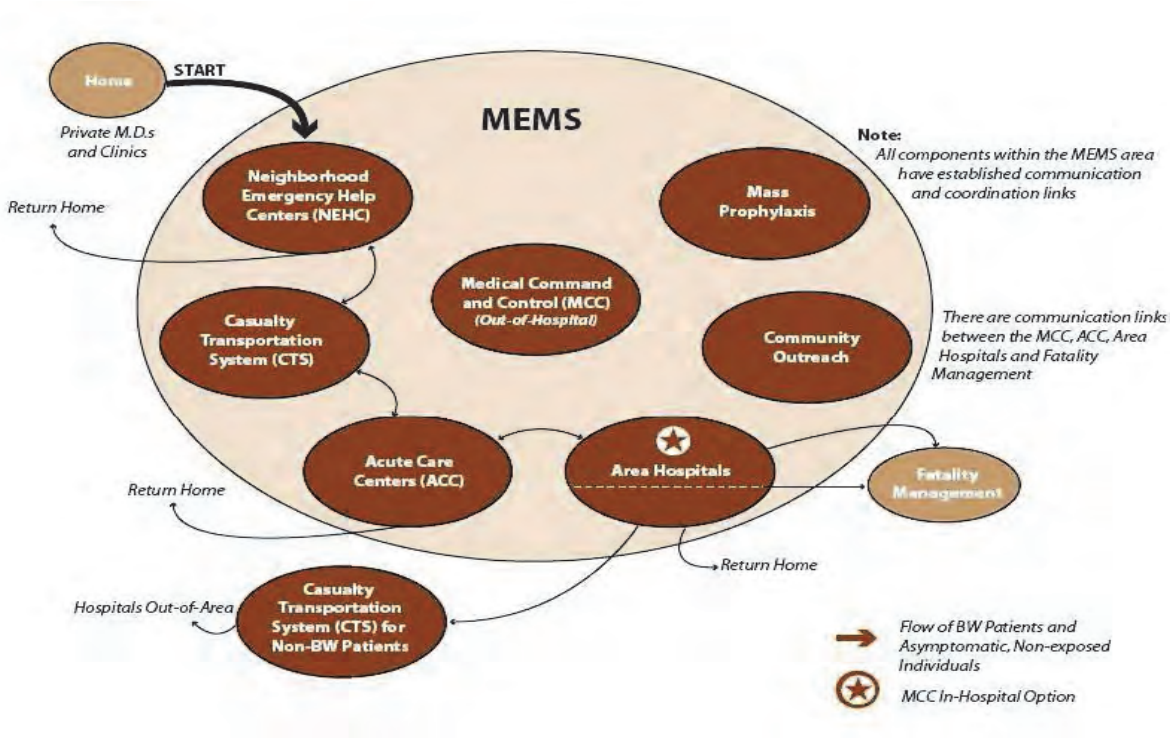
- Additional guidance on standards of care may be found in Altered Standards of Care in Mass Casualty Events, a document prepared by the AHRQ and found at http://www.ahrq.gov/research/altstand/. The MEMS described below also provides guidance on altered standards of care in CBRNE and mass casualty events.

d. **Modular Emergency Medical System (MEMS)**

- The Modular Emergency Medical System (MEMS) is an organizational structure that may be used in catastrophic health emergencies. The MEMS is designed to address the gap in casualty care resources that would exist if large numbers of victims were in need of acute care. MEMS was designed by the U.S. Department of Defense and is based on ICS principles.

- Using the MEMS structure, area hospitals would first establish a Regional Healthcare Coordination System (RHCS) and a Regional Healthcare Coordination Center (RHCC) as described under "Incident Management" and ESF 8 – Concept of Operations. Once activated, the RHCC may expand to include LPHAs/LHDs and other elements to form a Medical Command Center (MCC). Then, working with LPHAs/LHDs and local EMAs, hospitals may work to establish two types of expandable patient care modules, the Neighborhood Emergency Help Center (NEHC) and the Alternate Care Site (ACS). The MEMS concept also includes the establishment of a Casualty Transportation System, Community Outreach, Mass Prophylaxis and Public Information activities as required by the event. This organization is illustrated in Figure 5.

Figure 5: Modular Emergency Medical System



e. **Movement of Patients to Other Areas**

- The determination to move patients outside the region area for care or treatment will be made by local Public Health Directors in consultation with Hospital ICs and the RHCC, if activated. Patient transportation will be performed by local EMS agencies and coordinated through local EOCs.

- In the event patients must be moved outside the metro-area, the resources of the National Disaster Medical System (NDMS) will be requested through local EOCs. If NDMS resources are unavailable, patients may be transported to other hospitals in Kansas and Missouri using local and if available, state resources. For more information, see Attachment I – Forward Movement of Patients.

Emergency Credentialing

a. **Missouri and Kansas**

- Currently, credentialing and access to healthcare volunteers is done through the following: In Missouri the program is Show-Me response and can be accessed at https://showmeresponse.org/. In Kansas the program is http://www.kdheks.gov/it_systems/k-serve.htm.

b. **Regional**

- Each of the metro-area hospitals participating in the Memorandum of Agreement (see Attachment O) will solicit credentialed members of their active medical staff and other hospital employees to volunteer to assist the other participating hospitals during emergencies.

- These volunteers will submit their credentialing information to MARC for entry into a volunteer database. Once entered into the system, volunteers will receive a badge with a unique bar code. When deployed to another hospital, badges of the volunteer medical staff will be scanned at the recipient hospital for verification of credentials. Badging will be accomplished through use of KCTEAM. (see RCG: ESF 7 - Logistics)

- When an emergency requiring additional staff occurs, the Hospital ICs will request personnel resources through the EMCC or if activated, the RHCC. Once notified of the need for additional personnel, the RHCC or EMCC will ask hospitals to identify available staff not needed at their home hospital. Once deployed, volunteer clinical personnel may be paired with a staff member in the recipient hospital who will serve as their immediate supervisor. After the disaster, hospitals must complete their own credentialing of any personnel used according to JCAHO standards.

c. **National Efforts**

- Both Missouri and Kansas are members of the Emergency Management Assistance Compact (EMAC), a mutual aid agreement allowing states to assist one another during emergencies. EMAC establishes a legal foundation for states to send assistance to, and receive assistance from other states during state declared emergencies. A credentialing procedure is in place for medical personnel deployed under EMAC.

- The Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) is a federal program created to support states and territories in establishing standardized volunteer registration programs for disasters and public health and medical emergencies.

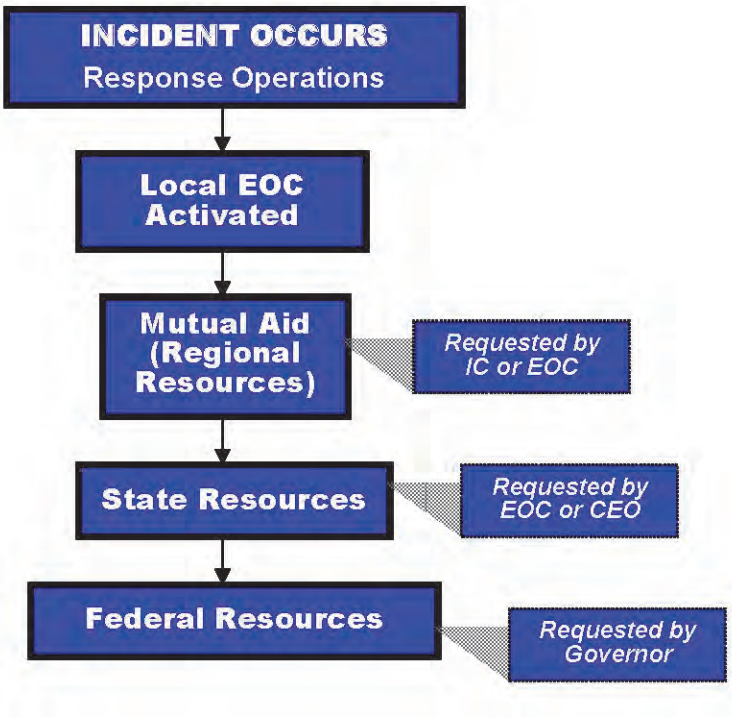
  The program, administered on the state level, verifies health professionals' identification and credentials so that they can respond more quickly when disaster strikes. By registering through ESAR-VHP, volunteers' identities, licenses, credentials, accreditations, and hospital privileges are all verified in advance, saving valuable time in emergency situations. In Missouri the program is Show-Me response and can be accessed at https://showmeresponse.org/. In Kansas the program is http://www.kdheks.gov/it_systems/k-serve.htm.

Coordination with Local Government

- Maintaining communications and coordinating with the EMAs and LPHAs/LHDs in each jurisdiction's EOC is critical to ensuring the support necessary for hospital operations. Working closely with local government will also help to ensure the timely request of state and federal resources.

- Local EOCs will maintain contact with their respective states, and requests for federal assistance and resources (e.g., National Guard, the NDMS and the SNS) will be made through local EOCs to State EOCs as illustrated in Figure 6.

Figure 6: Requesting State and Federal Resources



- The hospitals and when activated, the RHCS, will maintain communications with local EOCs and LPHAs/LHDs via telephone, radio and the Internet. When possible, hospitals will be linked to local EOCs using the capabilities of WebEOC, a web based crisis information management system. Standardized reporting procedures for the hospitals when using WebEOC are under development.

- Hospitals and/or the RHCC will provide information on patient and hospital status to local EOCs. Hospitals may also be asked to provide representation and/or information to the Joint Information Centers (JICs) established by local jurisdictions to coordinate the timely release of emergency public information.

- Hospitals will maintain communications with LPHAs/LHDs through the EOC and/or with the Health Operations Centers that may be established by local communities in the event of a Biological Incident.

- Hospitals may request Fire Department assistance with decontamination by contacting the Incident Commander or local EOC. Hospitals may request law enforcement assistance in preventing contaminated "walk-in" patients from entering and contaminating the emergency department or other portion of hospital facilities or operations by contacting the Incident Commander or local EOC.

Security

a. **General**

- Each hospital is responsible under the provisions of their Security Management Plan to develop, train and maintain the capability to protect staff, patients, visitors and the facility during a mass causality incident or CBRNE event.

- When an event occurs, the Hospital IC will implement applicable security measures appropriate based on guidance from the Missouri Department of Health and Senior Services (DHSS) the Kansas Department Health and Environment (KDHE). Based on the threat, this may include the implementation or enhancement of restricted access procedures (i.e., “lock down” of the facility).

- The purpose of restricted access is to prevent secondary contamination and to keep existing staff and patients from exiting and becoming exposed. The Hospital IC will determine the extent of restricted access procedures. Actions may include securing all doors and restricting entry into and out of the hospital, except for a single entry and exit point near the hospital's decontamination station.

- When restricted access is implemented, staff must present their hospital issued identification at pre-designated staff entrance(s). If staff do not have their identification, a procedure must be in place to verify who they are and their need to enter a building or particular area of a building. A method to issue a temporary identification badge must be in place for employees and volunteers.

- Security enhancements must also be in place to effectively control incoming patients at designated processing points, such as the decontamination, triage and waiting areas. There may be a need to erect barriers to designate boundaries and prevent patients from circumventing the triage and decontamination areas. In this case, security will be required to protect staff, monitor patient flow and enforce the boundaries of decontamination zones.

- A close designated parking area should be established for mass causality patients that drive or are driven to the hospital in their own vehicles. Security presence may also be necessary to keep the roadways leading to the hospital and/or decontamination areas from becoming blocked by traffic and/or unattended vehicles. Such vehicles should be segregated since they may be contaminated. There must be pre-arranged procedures in place to remove unattended vehicles through use of commercial tow services or local law enforcement.

- Facilities may request assistance with additional security personnel from local law enforcement through local EOCs, but should consider that their resources may be limited. If a facility does not have sufficient security personnel on duty to perform the necessary security functions and support is not available from local law enforcement, they should consider any or all of the following:

    1. Recall all off-duty security personnel

2. Request assistance from other hospitals in the region

3. Request augmentation of security personnel through private security companies

4. Request assistance in through the RHCC if activated

5. Request outside assistance through local EOCs, who will request resources from the state, if local resources are exhausted

- Patient belongings must be safeguarded and protected since they might be contaminated and/or evidence. An ID tag should be affixed to the belongings bag to identify the owner. Patient belongings will not be released to patients until authorized by local law enforcement.

b. **Family and Visitor Control**

- There should be a designated location for patient's families and visitors away from the decontamination and treatment areas. It is recommended that mental health services, social workers, clergy or similar services assist with families until escorted to the patient after admission or discharge. These crisis intervention resources may be provided by the hospital and/or coordinated through the local EOC.

- Media briefing areas should be established away from the decontamination and treatment areas and patient privacy will be considered. The hospitals Public Relations Departments should be involved and provide guidance on media briefing areas, etc. The hospital Public Relations Department will coordinate with the local EOCs and JICs to release consistent information about patient and visitor procedures.

Equipment, Pharmaceuticals and Supplies

a. **Personal Protective Equipment**

- The safety of hospital medical personnel, in particular clinicians and hospital staff who have a role in receiving and treating contaminated victims (e.g., triage, decontamination, medical treatment and security) must be considered during a CBRNE event.

- Metro-area hospital personnel have access to sufficient Personal Protective Equipment (PPE) for most situations. PPE maintained by area hospitals in both Kansas and Missouri includes sufficient protection as prescribed for Tier I hospitals.

- PPE maintained by local hospitals includes:

1. Biological: Hospitals have adequate supplies of infection control materials (gloves, gowns, and N95 or HEPA masks) for their clinical care personnel for at least the first 48 hours of an event.

2. Chemical: The minimum standard is Level C PAPRs with chem/bio filter packs (i.e., the same protection being used by police and EMS responders). Hospitals may train and equip with Level B, but the use of Level C is consistent recommendations for hospitals.

- Hospitals will use their own PPE first and call their regular suppliers and vendors to order additional equipment. If there is an immediate need for additional PPE, hospitals will contact other regional hospitals, local EOCs or if activated, the RHCC, to request assistance.

b. **Pharmaceuticals**

- Hospital pharmacies maintain a reasonable, daily inventory of antibiotics currently recommended for the treatment of patients with suspected or diagnosed bacterial biological agent. Hospitals emergency plans include procedures for obtaining additional pharmaceuticals for prophylaxis distribution to patients, patient's families, employees and employee families.

- In the event of a biological event, hospitals may develop and implement criteria for ceasing the non-essential use of prophylactic and therapeutic antibiotics until additional pharmaceutical assets are available.

- During medical emergencies, the availability of essential hospital pharmaceuticals may be determined by surveying hospital pharmacies. This may be accomplished by the affected Hospital IC, or by the RHCS when activated. During a major event, the RHCC may maintain a regional inventory by surveying hospitals and their pharmacies on a daily basis.

- Nerve agent antidote auto-injectors are available in the Mark I Kits currently stored at area emergency service agencies and at fourteen (14) metro-area hospitals. Protocols for the use of the Mark I Kits are maintained by the hospitals and EMS agencies.

- The Missouri DHSS has provided "CHEMPACK" capabilities for several hospitals in the Kansas City metropolitan area. Each CHEMPACK container includes enough antidotes to treat 1000 victims. Kansas hospitals expect to receive CHEMPACK capabilities in the near future. The number of containers placed in states and jurisdictions will be based on the population and ability of a community to properly store and monitor the caches. As additional information becomes available, it will be added to this Attachment as appropriate.

- Another initiative currently under way to increase pharmaceutical capabilities in the region is MEDS\POD, a mass prophylaxis dispensing system. It is anticipated that the eventual deployment and use of MEDS\POD by the metro-area hospitals will enhance their ability to provide priority prophylaxis.

- When necessary, local law enforcement may provide appropriate security for transportation of pharmaceuticals to hospitals as described in the law enforcement annexes and public health related emergency response plans maintained by local jurisdictions.

- If necessary, the resources of the Strategic National Stockpile (SNS) will be requested by LPHAs/LHDs and local EOCs to provide additional pharmaceutical supplies for the region.

- DHSS in Missouri and KDHE in Kansas are responsible for distribution and transportation to, and security at SNS receiving, staging, storage and distribution locations. Once in the region, LPHAs/LHDs have identified local support resources and developed procedures for the distribution of SNS materials.

- Hospitals are responsible for coordinating with LPHAs/LHDs and the state to order and receive SNS pharmaceuticals and supplies. Hospitals will provide adequate security, accountability, and

storage for SNS pharmaceuticals and supplies once they have been delivered and received at the hospital's designated Point of Dispensing (POD).

c. **Other Supplies**

- Each hospital has established plans for obtaining additional supplies (i.e. food, water, electricity, etc.) in the event of an emergency, including contracts with outside vendors to provide these services. Contractor contingency plans are on file in area hospitals as a part of their emergency plans.

- Medical supplies such as intravenous fluids, bandages, etc. may be in short supply. The nature of the incident will determine specific needs making it difficult to pre-stock significant quantities of disposables. In general, such medical supplies will be ordered through regular channels and/or obtained from other metro-area hospitals.

- If additional supplies are needed, assistance will be requested from the local EOC and/or the RHCS when activated. During major events, the RHCC may maintain a regional inventory of supplies and assist in distributing them to hospitals and other healthcare facilities.

- The metro-area hospitals maintain updated lists of transportation resources, such as facility owned vans, ambulances and other vehicles that may assist with transportation needs. Additional transportation resources to move patients, equipment and supplies will be coordinated through local EOCs.

d. **Mobile Equipment and Supplies**

- Augmentation of available hospital pharmaceuticals, PPE and supplies is available through mobile hospital trailers, MCI trailers and public health trailers strategically located throughout the metro-area. The location of MCI equipment caches is found in the MARCER MCI Plan.

- The metro-area also maintains an NDMS Disaster Medical Assistance Team (DMAT) with trained medical personnel and equipment resources ready for deployment. If regional DMAT personnel are not otherwise engaged in the emergency, they may be available to assist with the incident. A summary of the DMAT resources are found in Appendix 6.

D. Post-Incident (Recovery)

- Hospitals will continue operations as required by the event. As the needs of the incident decrease, hospitals will gradually return personnel and resource assignments to normal.

- Hospitals will continue coordination and communications with local EOCs, as well as established regional coordination centers, throughout the recovery phase.

- As necessary, all supplies, PPE and pharmaceuticals will be inventoried and restocked.

- Hospitals will conduct after action briefings and evaluate the effectiveness of their emergency response. Based on lessons learned, appropriate revisions and/or enhancements will be made to their emergency plans and procedures.

- Hospitals will work with the MARC to make modifications and/or enhancements to this Hospitals and Healthcare Systems Attachment based on lessons learned from real events.

- Based on lessons learned, hospitals will review the need to conduct additional training and exercises to improve future response activities.

- If necessary, local governments will request federal disaster assistance through their respective state agencies. Local governments will work closely with state and federal agencies to administer and coordinate disaster assistance programs.

III. Responsibilities

- Specific hospital responsibilities during a CBRNE or mass casualty event are detailed in the emergency plans and procedures maintained by each facility. The responsibilities described in the table below are not intended to be all inclusive, but rather to complement the responsibilities assigned in hospitals emergency plans and reinforce the activities described in this Attachment.

Metro-Area Hospitals

ORGANIZATION	RESPONSIBILITIES
HOSPITALS AND HEALTHCARE FACILITIES	• Participate in regional coordination activities to improve readiness for a mass casualty incident or CBRNE event • Take part in regional planning, training and exercise activities in order to strengthen regional preparedness • Ensure the capability exists to establish the Hospital Emergency Incident Command System (HEICS) and a Hospital Command Post/Center at each hospital • Work with local Emergency Management agencies and LPHAs/LHDs to establish procedures for coordination during a mass casualty event • Provide appropriate training to personnel on performing specialized tasks required in response to a mass casualty or CBRNE event • Work to ensure emergency plans, operating procedures, guidelines and other supporting documents are up to date and coordinated • When necessary, implement hospital emergency plans, and establish a Hospital Incident Commander and a Hospital Incident Command Center • Maintain communications with the LPHA/LHD representative in the local EOC • Coordinate with the local EOC to activate mutual aid and request state and federal resources if necessary • Provide information to the Health and Medical Services Coordinator in the EOC on hospital conditions and other information as requested • Establish and maintain communications with the EMS agencies and the Incident Commander • Provide appropriate hospital related information for release to the public and the media and if requested, provide a representative to the local EOC or JIC • Provide medical guidance as requested to EMS agencies • Coordinate with the EMCC, other hospitals and the Incident Command/Unified Command System (IC/UC) to ensure casualties are transported to the appropriate medical facility • Distribute patients to hospitals both inside and outside the area based on severity and types of injuries, time and mode of transport, capability to treat, bed capacity and special designations such as trauma and burn centers • If necessary, work with local government to coordinate the use of clinics and other care centers to treat less than acute illnesses and injuries

	• Coordinate with local emergency responders to isolate and decontaminate incoming patients to avoid the spread of hazardous substances or agents to other patients and staff • Coordinate with other hospitals and EMS on the evacuation of patients from affected hospitals, and specify where patients are to be taken • Establish and staff a reception and support center for the relatives and friends of disaster victims who may converge at the hospital • Provide patient identification information to the American Red Cross

Local Governments

- All local governments understand the importance of coordinating with hospitals and healthcare systems during a mass casualty incident and will work to accomplish the following activities in support of area hospitals and healthcare systems:

ORGANIZATION	RESPONSIBILITIES
ALL AGENCIES	• Actively participate in activities designed to improve coordination and communication with local hospitals • Involve hospitals and healthcare facilities in planning, as well as other preparedness activities such as training and exercises
EMERGENCY MANAGEMENT AGENCIES	• Activate the EOC and implement the EOP in support of Hospitals and Healthcare Systems activities in a mass casualty or CBRNE event • Coordinate the activities of other local departments, agencies and volunteer organizations to support the emergency actions of hospitals and healthcare facilities • Ensure the necessary logistical and resource support is provided to hospitals and healthcare facilities • Coordinate with hospitals to ensure adequate technology is available to ensure ongoing communications during an event (e.g., WebEOC) • Coordinate with the state emergency management agencies to ensure the timely request of state and federal assistance to support mass casualty operations
LOCAL PUBLIC HEALTH AGENCIES/ DEPARTMENTS (LPHAs/LHDs)	• Serve as the liaison between the hospitals and healthcare agencies involved in the event and local government operations • Provide information to and collect information from hospitals and healthcare agencies • Provide information to hospitals and healthcare agencies regarding public health issues associated with the event such as isolation and quarantine precautions • Issue health and medical advisories to the public on public health related matters • Coordinate the location, procurement, and allocation of health and medical supplies and resources, including human resources, required to support health and medical operations • Monitor the EMSystem and WebEOC; provide appropriate input and feedback to hospitals • Establish preventive health services including the control of communicable diseases • Organize the distribution of appropriate vaccines, drugs and antidotes, and coordinate immunization programs • Work with neighboring public health agencies, as well as with state and federal officials to augment health and medical resources
COUNTY SHERIFFS AND MUNICIPAL	• Provide security assistance to medical facilities and to health and medical field personnel upon request

POLICE DEPARTMENTS	• If necessary, provide crowd control, traffic flow and parking assistance around hospitals and other health and medical facilities • Provide for emergency health services at correctional facilities, if appropriate and necessary
LOCAL FIRE DEPARTMENTS	• Serve as the lead agency for decontamination in the field and provide assistance with decontamination at local hospitals upon request
EMERGENCY MEDICAL SERVICE (EMS) AGENCIES	• Respond to the disaster scene with emergency medical personnel and equipment and upon arrival, assume an appropriate role in the IC/UC • If necessary, establish a medical command post at the disaster site(s) to coordinate health and medical response team efforts • Provide triage, initial medical care and transport for the injured • Establish and maintain field communications with hospitals and other responding agencies • Assist with the evacuation of patients from affected hospitals if necessary and requested
VOLUNTEER AGENCIES	• Maintain a Disaster Welfare Information (DWI) system in coordination with hospitals, EMS, aid stations, and field triage units to collect, receive, and report information about the status of victims. Provide DWI to the ESF #8 (Public Health and Medical) Coordinator for appropriate dissemination • Assist with the provision of food for emergency medical workers, volunteers and patients, if requested • Assist with notification of the next of kin of injured and deceased • Assist with the reunification of the injured with their families. • Provide first aid and other related medical support (within capabilities) at temporary treatment centers Medical Reserve Corps • Provide supplementary medical and nursing aid and other health services, when requested and within capabilities

Other Agencies

ORGANIZATION	RESPONSIBILITIES
MID-AMERICA REGIONAL COUNCIL	• Facilitate continued planning to support the activities described in this Attachment • Ensure adequate training and exercises are conducted in support of this Attachment • Maintain the capability to facilitate coordination activities among the hospitals and healthcare systems to help strengthen regional preparedness (i.e., the RHSCC Hospital Subcommittee) • Sponsor and facilitate other regional preparedness initiatives
STATE AND FEDERAL AGENCIES	• Provide additional resources, personnel and technical assistance to support public health and medical activities in response to a CBRNE or mass casualty event

IV. Appendices

1. Metropolitan Area Hospital
   a. Addendum A – Surge Capacity

2. Regional Hospital Memorandum of Understanding
   a. Addendum A – Primary Data Collection Form
   b. Addendum B – Secondary Data Collection Form (Beds)
   c. Addendum C – Secondary Data Collection Form (Staff)
   d. Addendum D – Hospitals Directory Information Form
   e. Addendum E – Letter of Agreement

3. National Disaster Medical System (NDMS) Memorandum of Understanding
4. Missouri Tier I Hospital Capabilities
5. Federally Qualified Health Centers and Ambulatory Surgery Centers
6. Local Disaster Medical Assistance Team (DMAT) Resources

Appendix 1: Metro Regional Hospitals

To access the most current list of hospitals, see:

- EMResource
- If you do not have access, contact the Mid-America Regional Council

Addendum A to Appendix 1: Regional Hospital Surge Capacity

HOSPITALS BY COUNTY	ON-SITE SURGE CAPACITY Method and Approximate Number of Patients	OFF-SITE SURGE CAPACITY Method and Approximate Number of Patients
CASS		
Cass Medical Center Research Belton Hospital		
CLAY		
Excelsior Springs Medical Center		
* Liberty Hospital	50 (by using Surgical Service, EAU, specials, early dismissal)	100 (would use local school, working on Liberty Junior High)
* North Kansas City Hospital		
St. Luke's Hospital Smithville		
JACKSON		
* Children's Mercy Hospital		
* Independence Regional Medical Center	36 (utilizing unused in-patient and hall beds)	100 (utilize unused north tower of hospital; nothing set up completely off-site)
Lee's Summit Hospital	100 (utilizing open current unused rooms; and OPS and SDS bays)	20 – 40 (may be able to use John Knox Pavilion for patients needing minimal care)
Medical Center of Independence	32 (utilizing unused in-patient and hall beds)	0 (nothing set up at this time)
* St. Luke's Hospital of Kansas City		
St. Luke's Hospital East		
Truman Medical Center–Hospital Hill	40-100 (by opening unused care areas)	
* Truman Medical Center – Lakewood		
* Research Medical Center		
St. Mary's Hospital		
* St. Joseph Medical Center		
JOHNSON		
Children's Mercy South		
Menorah Medical Center		
Olathe Medical Center		
Overland Park Regional Medical Center		
St. Luke's Hospital South		
Shawnee Mission Medical Center		
LEAVENWORTH		
Cushing Hospital		
St. John's Hospital		
PLATTE		
* St. Luke's Northland Hospital		
RAY		
Ray County Hospital		
WYANDOTTE		
Providence Medical Center	35	18
University of Kansas Hospital		

* These hospitals maintain mobile trailers with medical supplies and equipment

NOTE: In addition to the on and off site surge capacity developed by each facility as noted above, many of the metro-area hospitals are currently working with Emergency Management officials to identify large, centrally located facilities that could be established as Alternate Care Sites (ACSs). As these facilities are identified, they should be included in local EOPs and hospital plans.

Appendix 2: Metropolitan Regional Hospital Mutual Aid Memorandum of Understanding

Note: This MOU is preserved for historical reference. See the Missouri Hospital Mutual Aid Agreement in Attachment O for the most current and active version.

I. Introduction and Background

The Kansas City Metropolitan Area is susceptible to disasters, both natural and man- made, that could exceed the resources of any individual Metropolitan hospital. A disaster could result from incidents generating an overwhelming number of patients, from a smaller number of patients whose specialized medical requirements exceed the resources of the impacted facility (e.g., hazmat injuries, pulmonary, trauma surgery, etc.), or from incidents such as building or plant problems resulting in the need for partial or complete hospital evacuation.

II. Purpose of Mutual Aid Memorandum of Understanding

The mutual aid support concept is well established in most emergency response disciplines. The purpose of this mutual aid support agreement is to aid hospitals in their emergency management by authorizing a Hospital Mutual Aid System (H-MAS). H-MAS addresses the loan of medical personnel, pharmaceuticals, supplies, and equipment, or assistance with emergent hospital evacuation, including accepting transferred patients.

This Mutual Aid Memorandum of Understanding (MOU) is a voluntary agreement among the signatory members of the Kansas City Metropolitan Area Hospitals, for the purpose of providing mutual aid at the time of a medical disaster. For purposes of this MOU, **a medical disaster** is defined as an overwhelming incident that **exceeds the effective response capability** of the impacted health care facility or facilities. An incident of this magnitude will almost always involve the Kansas City Metropolitan Area Emergency Management Agency having jurisdiction, e.g. City or County (EMA) and Local Public Health Agency (LPHA) e.g. City or County (LPHA). The disaster may be an "external" or "internal" event for hospitals and **assumes that each affected hospital's emergency management plans have been fully implemented.**

This document addresses the relationships between and among hospitals and is intended to augment, not replace, each facility's disaster plan. The MOU also provides the framework for hospitals to coordinate as a single H-MAS community its actions with EMA, LPHA and EMS during planning and response. This document does not replace but rather supplements the rules and procedures governing interaction with other organizations during a disaster, e.g., law enforcement agencies, the EMA, LPHA, fire departments, American Red Cross, etc. By signing this Memorandum of Understanding each hospital is evidencing its intent to abide by the terms of the MOU in the event of a medical disaster as described above; the terms of this MOU should be incorporated into the hospital's emergency management plans.

III. Definition of Terms

Hospital Command Center: An area established in a hospital during an emergency that is the facility's primary source of administrative authority and decision-making.

Donor Hospital: The hospital that provides personnel, pharmaceuticals, supplies, or equipment to a facility experiencing a medical disaster. Also referred to as the patient-receiving hospital when involving evacuating patients.

EMSystem Coordination Centers (EMCC): The EMSystem Coordination Centers (EMCC) will function as a communication and information center. They have interoperability radio system and EMSystem network capabilities allowing for the immediate determination of available hospital resources at the time of a disaster. The EMCC will be operational 24 hours a day and requires daily maintenance. The EMCC does not have any decision-making or supervisory authority but merely collects and disseminates information, and performs radio checks of the interoperability radio system.

H-MAS: Hospital Mutual Aid System

Impacted Hospital: The hospital where the disaster occurred or disaster victims are being treated. Referred to as the recipient hospital when pharmaceuticals, supplies, or equipment are requested, or as the patient-transferring hospital when the evacuation of patients is required.

Interoperability Radios System: The primary radio communication system used by hospitals to communicate during an emergency (MARCER Med Channel Communications System).

Medical Disaster: An incident that exceeds a facility's effective response capability or cannot appropriately resolve solely by using its own resources. Such disasters will very likely involve the EMAs and LPHAs having jurisdiction. Management of the event may involve loaning of medical/support personnel, pharmaceuticals, supplies, and equipment from another facility, or, the emergent evacuation of patients.

National Incident Management System (NIMS): The nationally standardized incident management system accepted and used in conjunction with the Incident Command System (ICS) used by local emergency services agencies and the Hospital Emergency Incident Command System (HEICS) used by the metropolitan area hospitals.

Partner ("Buddy"): The designated facility that a hospital communicates with as a facility's "first call for help" during a medical disaster (developed through an optional partnering arrangement).

Patient-Receiving Hospital: The hospital that receives transferred patients from a facility responding to a disaster. When patients are evacuated, the receiving facility is referred to as the patient-receiving hospital. When personnel or materials are involved, the providing hospital is referred to as the donor hospital.

Patient-Transferring Hospital: An impacted facility. The hospital that evacuates patients to a patient-receiving facility in response to a medical disaster (also referred to as the recipient hospital when personnel and materials are moved to the facility).

Participating Hospitals: Healthcare facilities that have agreed to and signed MOU for H-MAS.

Recipient Hospital: The impacted facility. This is the hospital where disaster patients are being treated and has requested personnel or materials from another facility (also referred to as the patient-transferring hospital when evacuating/transferring patients from the facility during a medical disaster).

Regional Hospital Coordination Center (RHCC): A site established during major emergencies to coordinate hospital resources and serve as the central point for hospital related information.

Regional Hospital Coordination System (RHCS): A system established to help ensure communication, coordination and resource sharing among the hospitals in the Kansas City metropolitan area. When activated, the RHCC is a component of the RHCS.

RHCS Liaisons: Individuals designated by participating hospitals to activate the RHCS and when necessary, the RHCC. The RHCS Liaisons are hospital Emergency Management Planners and in most cases, members of the Regional Homeland Security Committee (RHSCC) Hospitals Subcommittee Planning Task Force.

RHCC Leadership Team: Individuals designated by participating hospitals to serve a leadership role in the RHCC. Members of the RHCC Leadership Team will have the authority to commit hospital resources and personnel.

IV. General Principles of Understanding

6. **Participating Hospitals:** Each hospital designates a representative to attend the Hospital Mutual Aid System meetings and to coordinate the mutual aid initiatives with the individual hospital's emergency preparedness/management plans. Hospitals also commit to participating in H-MAS exercises and maintaining their radio links to interoperability radio system.

7. **Partner Hospital Concept:** Each hospital has the option of linking to a designated partner or "buddy" hospital as the hospital of 'first call for help' during a disaster. The hospitals comprising each partner-network should develop, prior to any medical disaster, methods for coordinating communication between themselves, responding to the media, and identifying the locations to enter their buddy hospital's security perimeter.

8. **Implementation of Mutual Aid Memorandum of Understanding:** A health care facility becomes a participating hospital when an authorized administrator signs the MOU. During a medical emergency, only the authorized administrator (or designee) or command center at each hospital has the authority to request or offer assistance through H-MAS. Communications between hospitals for formally requesting and volunteering assistance should therefore occur among the senior administrators (or designees) or respective command centers.

9. **Command Center:** The impacted facility's command center is responsible for informing the EMCC of its situation and defining needs that cannot be accommodated by the hospital itself or any existing partner hospital. The senior administrator or designee is responsible for requesting personnel, pharmaceuticals, supplies, equipment, or authorizing the evacuation of patients. The senior administrator or designee will coordinate both internally, and with the donor/patient-accepting hospital, all of the logistics involved in implementing assistance under this Mutual Aid MOU. Logistics include identifying the number and specific location where personnel, pharmaceuticals, supplies, equipment, or patients should be sent, how to enter the security perimeter, estimated time interval to arrival and estimated return date of borrowed supplies, etc.

10. **EMCC:** Each hospital will participate in an annual H-MAS exercise that includes communicating to the EMCC a set of data elements or indicators describing the hospital's resource capacity. (See attached forms, pp. 13-15.) The EMCC will serve as an information center for recording and disseminating the type and amount of available resources at each hospital. During a disaster drill or emergency, each hospital will report to the current status of their indicators. (For a more detailed account of the EMCC Operations, see "EMSystem Protocols and Policies.") Hospitals also participate in daily radio checks performed by the EMCC.

11. **Hospital Indicators:** A set of hospital resource measures that are reported to the Communication Center during a disaster drill or actual disaster. The indicators are designed to catalogue hospital resources that could be available for other hospitals during a disaster.

12. **Documentation:** During a disaster, the recipient hospital will accept and honor the donor hospital's standard requisition forms. Documentation should detail the items involved in the transaction, condition of the material prior to the loan (if applicable), and the party responsible for the material.

13. **Authorization:** The recipient facility will have supervisory direction over the donor facility's staff, borrowed equipment, etc., once they are received by the recipient hospital.

14. **Financial Liability for Loaned Equipment:** The recipient hospital will reimburse the donor hospital, to the extent permitted by federal and state law, for all of the donor hospital's costs for all use, breakage, damage, replacement, and return costs of borrowed materials, and reasonable expenses, and for reasonable costs of defending any liability claims, except where the donor hospital has not provided preventive maintenance or proper repair of loaned equipment which resulted in patient injury. Reimbursement will be made within ninety days following receipt of the invoice.

15. **Communications:** Hospitals will collaborate on the EMSystem and the interoperability radio system to ensure a dedicated and reliable method to communicate with the EMCC and other hospitals. The back-up conference call landline telephone system may be used as a semi-secure system for discussing sensitive information.

16. **Public Relations:** Each hospital is responsible for developing and coordinating with other hospitals and relevant organizations the media response to the disaster. Hospitals are encouraged to develop and coordinate the outline of their response prior to any disaster. The partner hospitals should be familiar with each other's mechanisms for addressing the media. The response should include reference to the fact that the situation is being addressed in a manner agreed upon by a previously established mutual aid protocol.

17. **Regional Hospital Coordination System (RHCS):** During major emergency events, the participating hospitals have agreed that a system may be established to facilitate coordination and resource sharing among the affected facilities. The RHCS will be activated based scope of the event and activities may range from information sharing among established Hospital Command Centers via conference calls, to the activation and staffing of a Regional Hospital Coordination Center (RHCC). In major emergencies, an RHCC may be activated to serve as the central coordination point for hospital information and resources. Participating hospitals will designate individuals to serve as RHCS On-Call Liaisons available to activate the RHCS, as well as individuals to serve as members of the Leadership Team when the need arises to activate the RHCC.

18. **Emergency Management Committee Chairperson:** Each hospital's Emergency Management Committee Chairperson or designee is responsible for disseminating the information regarding this MOU to relevant hospital personnel, coordinating and evaluating the hospital’s participation in exercises of the mutual aid system, and incorporating the MOU concepts into the hospital’s emergency management plan.

V. General Principles Governing Medical Operations, the Transfer of Personnel, Pharmaceuticals, Supplies, Equipment, or the Evacuation of Patients

5. **Partner hospital concept:** Each hospital has the option of designating a partner or buddy hospital that serves as the hospital of "first call for help." During a disaster, the requesting hospital may first call its pre-arranged partner hospital for personnel or material assistance or to request the evacuation of patients to the partner hospital. The donor hospital will inform the requesting hospital of the degree and time frame in which it can meet the request.

6. **EMCC:** The recipient hospital (patient-transferring hospital) is responsible for notifying and informing the EMCC of its personnel or material needs or its need to evacuate patients and the degree to which its partner hospital is unable to meet these needs. Upon the request by the senior administrator or designee of the impacted hospital, the EMCC will contact the other participating hospitals to determine the availability of additional personnel or material resources, including the availability of beds, as required by the situation. The recipient hospital will be informed as to which hospitals should be contacted directly for assistance that has been offered. The senior administrator (or designee) of the recipient or patient-transferring hospital will coordinate directly with the senior administrator (or designee) of the donor or patient-accepting hospital for this assistance.

7. **Initiation of transfer of personnel, material resources, or patients:** Only the senior hospital administrator or designee at each hospital has the authority to initiate the transfer or receipt of personnel, material resources, or patients. The senior administrator (or designee) and Medical Director or (or designee), in conjunction with the directors of the affected services, will make a determination as to whether medical staff and other personnel from another facility will be required at the impacted hospital to assist in patient care activities. Personnel offered by donor hospitals should be limited to staff that are **fully accredited, licensed, privileged or credentialed in the donor institution.** No resident physicians, medical/nursing students, or in-training persons should be volunteered. In the event of the evacuation of patients, the Medical Director or Designee of the patient-transferring hospital will also notify the local fire department of its situation and seek assistance, if necessary, from the local EMS. (The Fire Department will be requested to notify the Emergency Management Agency and the Department of Health.)

VI. Specific Principles of Understanding

Medical Operations/Loaning Personnel

1. **Communication of request:** The request for the transfer of personnel initially can be made verbally. The request, however, must be followed up with written documentation. This should ideally occur prior to the arrival of personnel at the recipient hospital. The recipient hospital will identify to the donor hospital the following:

   a. The type and number of requested personnel.

   b. An estimate of how quickly the request is needed.

   c. The location where they are to report.

   d. An estimate of how long the personnel will be needed.

2. **Documentation**: The arriving donated personnel will be required to present their donor hospital identification badge at the site designated by the recipient hospital's command center. The recipient hospital will be responsible for the following:

   a. Meeting the arriving donated personnel (usually by the recipient hospital's security department or designated employee).

   b. Confirming the donated personnel's ID badge with the list of personnel provided by the donor hospital.

c. Providing additional identification, e.g., "visiting personnel" badge, to the arriving donated personnel. The recipient hospital will accept the professional credentialing determination of the donor hospital but only for those services for which the personnel are credentialed at the donor hospital.

3. **Supervision:** The recipient hospital's senior administrator or designee (the Incident Commander) identifies where and to whom the donated personnel are to report, and the professional staff of the recipient hospital that supervises the donated personnel. The supervisor or designee will meet the donated personnel at the point of entry of the facility and brief the donated personnel of the situation and their assignments. If appropriate, the "emergency staffing" rules of the recipient hospital will govern assigned shifts. The donated personnel's shift, however, should not be longer than the customary length practiced at the donor hospital.

4. **Legal Liability:** Recipient Hospital will hold harmless Donor Hospital for any Liability claims, malpractice claims, disability claims, attorneys' fees, and other incurred costs resulting from the negligence or omissions of Recipient Hospital employees or agents. An extension of liability coverage will be provided by the recipient facility, to the extent permitted by federal and state law, insofar as the donated personnel are operating within their scope of practice. The recipient hospital will reimburse the donor hospital for the salaries of the donated personnel at the donated personnel's rate as established at the donor hospital if the personnel are employees being paid by the donor hospital. The reimbursement will be made within ninety days following receipt of the invoice. The Medical Director or Designee of the recipient hospital will be responsible for providing a mechanism for granting emergency credentialing privileges' for physicians, nurses and other licensed healthcare providers to provide services at the recipient hospital.

5. **Demobilization procedures:** The recipient hospital will provide and coordinate any necessary demobilization procedures and post-event stress debriefing. The recipient hospital is responsible for providing the donated personnel transportation necessary for their return to the donor hospital.

Transfer of Pharmaceuticals, Supplies or Equipment

1. **Communication of Request:** The request for the transfer of pharmaceuticals, supplies, or equipment initially can be made verbally. The request, however, must be followed up with a written communication. This should ideally occur prior to the receipt of any material resources at the recipient hospital. The recipient hospital will identify to the donor hospital the following:

   a. The quantity and exact type of requested items.

   b. An estimate of how quickly the request is needed.

   c. Time period for which the supplies will be needed.

   d. Location to which the supplies should be delivered. The donor hospital will identify how long it will take them to fulfill the request. Since response time is a central component during a disaster response, decision and implementation should occur quickly.

2. **Documentation:** The recipient hospital will honor the donor hospital's standard order requisition form as documentation of the request and receipt of the materials. The recipient hospital's security office or designee will confirm the receipt of the material resources. The documentation will detail the following:
   a. The items involved.

b. The condition of the equipment prior to the loan (if applicable).

c. The responsible parties for the borrowed material.

d. The donor hospital is responsible for tracking the borrowed inventory through their standard requisition forms.

e. Upon the return of the equipment, etc, the original invoice will be co-signed by the senior administrator or designee of the recipient hospital recording the condition of the borrowed equipment.

3. **Transporting of pharmaceuticals, supplies, or equipment:** The donor hospital is responsible for coordinating the transportation of materials to the recipient hospital. This coordination may involve government and/or private organizations, and the recipient hospital may also offer transport. Upon request, the receiving hospital must return and pay the transportation fees for returning or replacing all borrowed material.

4. **Supervision:** The recipient hospital is responsible for appropriate use and maintenance of all borrowed pharmaceuticals, supplies, or equipment.

5. **Liability for borrowed supplies and equipment:** The recipient hospital, to the extent permitted by federal and state law, is responsible for all costs arising from the use, damage, or loss of borrowed pharmaceuticals, supplies, or equipment from Donor Hospital, and for liability claims arising from the use of borrowed supplies and equipment, except where the donor hospital has not provided preventive maintenance or proper repair of loaned equipment which resulted in patient injury.

6. **Demobilization procedures:** The recipient hospital is responsible for the rehabilitation and prompt return of the borrowed equipment to the donor hospital.

Transfer/Evacuation of Patients

1. **Communication of request:** The request for the transfer of patients initially can be made verbally. The request, however, ideally must be followed up with a written communication prior to the actual transferring of any patients. The patient- transferring hospital will identify to the patient-accepting hospital:

   a. The number of patients needed to be transferred.

   b. The general nature of their illness or condition.

   c. Any type of specialized services required, e.g., ICU bed, burn bed, trauma care, etc.

2. **Documentation:** The patient-transferring hospital is responsible for providing the patient-receiving hospital with the copies of patient's complete medical records, insurance information and other patient information necessary for the care of the transferred patient. The patient-transferring hospital is responsible for tracking the destination of all patients transferred out.

3. **Transporting of patients:** The patient-transferring hospital is responsible for coordinating and financing the transportation of patients to the patient-receiving hospital. The patient-receiving

hospital's senior administrator or designee will designate the point of entry. Once admitted, that patient becomes the patient- receiving hospital's patient and under care of the patient-receiving hospital's admitting physician until discharged, transferred or reassigned. The patient- transferring hospital is responsible for transferring of extraordinary drugs or other special patient needs (e.g., equipment, blood products) along with the patient if requested by the patient-receiving hospital.

4. **Supervision:** The patient-receiving hospital will designate the patient's admitting service, the admitting physician for each patient, and, if requested, will provide at least temporary emergency privileges to the patient's original attending physician.

5. **Notification:** The patient-transferring hospital is responsible for notifying both the patient's family or guardian and the patient's attending or personal physician of the situation as soon as practical.

EMCC Function

The interoperability radio system provides the means for the hospitals to coordinate among themselves, and as a unit to integrate with EMA, LPHA, Police and EMS during a disaster event. The EMCC serves as the data center for collecting and disseminating current information about equipment, bed capacity and other hospital resources during a disaster. (See attached form, pp.13-15.) The information collected by the Communication Center is to be used only for disaster preparedness and response. In the event of a disaster or during a disaster drill, hospitals will be prepared to provide the communication center the following information:

1. The total number of injury victims your Emergency Department can accept, and if possible, the number of victims with minor and major injuries.

2. Total number of operating beds current available to accept patients in the following units:

   a. General medical (adult)
   b. General surgical (adult)
   c. General medical (pediatric)
   d. General surgical (pediatric)
   e. Obstetrics
   f. Cardiac intensive care
   g. Neonatal intensive care
   h. Pediatric intensive care
   i. Burn
   j. Psychiatric
   k. Subacute care
   l. Skilled care beds
   m. Operating suites

3. The number of items currently available for loan or donation to another hospital:

   a. Respirators
   b. IV infusion pumps
   c. Dialysis machines
   d. Hazmat decontamination equipment
   e. MRI
   f. CT scanner
   g. Hyperbaric chamber
   h. Ventilators

i. External pacemakers
j. Atropine
k. Other Pharmaceuticals

4. The following number of personnel currently available for loan to another hospital:

Physicians:
Anesthesiologists
Emergency Medicine
General Surgeon
OB-GYN
Pediatricians
Trauma Surgeons

Registered Emergency Nurses:
Critical Care
Operating Room
Pediatrics

Other Maintenance Workers/Personnel:
Mental Health Workers
Respiratory Therapists
Plant Engineers
Security Workers
Social Workers
Others as indicated

Partner Hospital Concept

Each Partner hospital should standardize a set of contacts to facilitate communications during a disaster. The procedural steps in the event of a disaster are as follows:

1. Determine the total number of patients the emergency department and hospital can accept, and if possible, the total number of patients with major and minor injuries.

2. Impacted hospital contacts partner hospital to determine availability of beds, equipment, supplies, and personnel. (Contacts secondary partner hospital if primary hospital is unable to meet needs.)

3. Impacted hospital contacts the EMCC and notifies the center of its needs, how they are being met, and any unmet needs.

4. At the request of the impacted hospital, the EMCC will contact other hospitals to alert them to the situation and to begin an inventory for any possible or actual unmet needs.

Addendum A to Appendix 2: Primary Data Collection Form

In the event of an emergency, record the time of communication, the total number of injury victims the receiving hospital can accept, and, if possible, the number of Emergent (Red), Urgent (Yellow), Non-Urgent (Green) injury victims the hospital can accept.

Date: _____ Page #_____

Hospital	Time	Non-Urgent	Urgent	Emergent	Total Number of Patients
Baptist Lutheran Hospital					
Cass Medical Center					
Children's Mercy Hospital *					
Cushing Hospital					
Excelsior Springs Medical Center					
Independence Regional Medical Center**					
Kindred Hospital					
Lafayette Regional					
Lawrence Memorial					
Lee's Summit Hospital					
Liberty Hospital**					
Medical Center of Independence					
Menorah Medical Center					
North Kansas City Hospital**					
Olathe Medical Center					
Overland Park Regional Medical Center**					
Providence Medical Center					
Ray County Hospital					
Research Belton Hospital					
Research Medical Center**					
Shawnee Mission Medical Center					
St. John's Hospital					
St. Joseph Health Center**					
St. Luke's Barry Rd. Hospital					
St. Luke's Hospital*					
St. Luke's Smithville Hospital					
St. Luke's South Hospital					
St. Mary's Hospital					
Truman Medical Center Lakewood					
Truman Medical Center – Hospital Hill*					
University of Kansas Medical Center*					
Veterans Administration Medical Center					
Western Missouri Medical Center					

* Level 1 Trauma Center.
** Level 2 Trauma Center

Addendum B to Appendix 2: Secondary Data Collection Form - Patient Care Bed and Equipment Availability Form

If time or need permits, request the following information from the donating hospital.

Hosp Name: _____

Person completing form: _____

Date: _____ Time: _____

Number of Open/Available Beds		Total Available to Donate	
General medical (adult)		Respirators	
General surgical (adult)		IV Infusion Pumps	
General medical (pediatric)		Dialysis Machines	
General surgical (pediatric)		Hazmat Decontamination Equipment	
Obstetrics		MRIs	
Cardiac ICU		CT Scanners	
NICU		Hyperbaric Chamber	
PICU		Ventilators	
Burn		External pacemakers	
Psychiatric		Atropine	
Trauma		Other Pharmaceuticals	
OR Suites			
Skilled Nursing & Subacute Care			
Isolation Rooms (Negative Pressure)			

* During an actual disaster or disaster drill, hospitals should complete the above form with the most current information available and have this information ready for dissemination to EMA, FD, requesting hospitals, via the interoperability radio system to the EMCC.

Addendum C to Appendix 2: Secondary Data Collection Form - Staff Availability Form

Hospital Name: _____

Person completing form: _____

Date: _____ Time: _____

Physician Number of Personnel Currently Available to Loan/Donate to Partner Hosp.*

Specialty	Number	Specialty	Number
☐ Anesthesiology		☐ OB-GYN	
☐ Emergency Medicine		☐ Pediatrician	
☐ General Surgeon		☐ Trauma Surgeon	
☐ General Medicine		☐ Other as indicated	

Registered Nurses

Specialty	Number	Specialty	Number
☐ Anesthesiology		☐ OB-GYN	
☐ Emergency Medicine		☐ Operating Room	
☐ Med/Surg		☐ Pediatrics	
☐ Critical Care		☐ Other as indicated	

Other Personnel

Specialty	Number	Specialty	Number
☐ Maintenance Workers		☐ Pharmacy Tech	
☐ Mental Health Workers		☐ Security Personnel	
☐ Respiratory Therapists		☐ Social Workers	
☐ Plant Engineers		☐ Other as indicated	

Addendum D to Appendix 2: Hospital Emergency Communications Directory Form

The following information on hospitals in the region is maintained by MARC.

Hospital Name: _____

Street Address: _____

City, State, Zip Code: _____

CEO: _____
Phone: _____
Fax: _____

Emergency Management Chair: _____
Phone: _____
Fax: _____

Emergency Department phone number: _____
Emergency Department Fax number: _____

Command Center phone number: _____
Command Center Fax number: _____

Page Operator phone number: _____
Dedicated disaster phone number: _____

Person completing this form: _____
Title: _____
Date: _____
Phone number: _____
E-mail address: _____

Addendum E to Appendix 2: MOU Letter of Agreement

The following letter of agreement will be signed by participating hospitals and kept on file with MARC

This Memorandum of Understanding shall become effective on _____, and shall continue in effect indefinitely, except that a Participant may terminate its participation in this Memorandum of Understanding by giving a sixty (60) day written notice to the other Participants of its intentions.

This Memorandum of Understanding shall be reviewed periodically. It may be amended upon the agreement of a two-thirds majority of then current Participants.

This Agreement is in no way meant to affect any of the Participants' rights, privileges, titles, claims, or defenses provided under federal or state law.

_____

Health Care Institution

_____

CEO/COO

_____

Date

Appendix 3: NDMS Memorandum of Agreement

Memorandum of Agreement

For Definitive Medical Care

1. PARTIES

The Parties to this Memorandum of Agreement are _____ (the Provider) and the National Disaster Medical System (NDMS) that consists of a coordinated partnership among the Department of Homeland Security, the Department of Health and Human Services, the Department of Veterans Affairs, and the Department of Defense, collectively the NDMS Federal Partners.

2. AUTHORITY

The Public Health Security and Bioterrorism Preparedness and Response Act of 2002, 42 U.S.C., 300hh-11, as amended by the Homeland Security Act of 2002, 6 U.S.C., 313(5) (the NDMS Statute).

3. PURPOSE

A. The NDMS statute provides that NDMS shall be a coordinated effort by the NDMS Federal Partners, working in collaboration with the States and other appropriate public or private entities, to (i) provide health services, health-related social services, other appropriate human services, and appropriate auxiliary services to respond to the needs of victims of a public health emergency and (ii) be present at locations, and for limited periods of time, when such locations are at risk of a public health emergency during the time specified.

B. This Agreement is to help ensure that the United States is prepared to respond medically to mass casualty emergency situations in this country, or to military patients returning from overseas by facilitating a coordinated response of both federal and civilian health care facilities.

C. The NDMS Federal Partners acknowledge the willingness of the various medical communities within the United States to respond to a catastrophic public health emergency, and the need for unusually rapid and complex response, transportation and treatment. A rapid response requires the development of a comprehensive emergency medical plan so that those patients needing definitive medical care would receive it in federal or private sector hospitals in the United States.

4. RESPONSIBILITIES

A. The NDMS Federal Partners and the Provider agree to plan jointly for the admission, treatment, and discharge of all patients transferred to the Provider's facility under the NDMS.

B. The Provider agrees to seek reimbursement from NDMS only after seeking reimbursement from all other payers, such as health insurers or TRICARE, except another Federally recognized payer of last resort, such as Medicaid.

C. Subject to the availability of appropriations, the NDMS will reimburse the Provider for medical treatment or services rendered by the Provider as indicated in paragraph 5 below.

D. The Provider agrees to participate in joint annual exercises meeting external disaster standards established by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Hospital Association.

E. The Provider agrees that upon activation of NDMS it will make available to the NDMS Federal Partners, a minimum of _____ to a maximum of _____ beds with all necessary treatment and administrative processing as may be required for the patients to be admitted as a consequence of the catastrophic public health emergency.

F. The Provider agrees to report the number of beds available when requested to support NDMS exercises or operations.

5. REIMBURSEMENTS

A. Reimbursements will be limited to care provided for: injuries or illnesses resulting directly from a specified public health emergency; injuries, illnesses and conditions requiring essential medical services necessary to

Memorandum of Agreement

maintain a reasonable level of health temporarily not available as a result of the public health emergency; or injuries or illnesses affecting authorized emergency response and disaster relief personnel responding to the public health emergency.

B. For patients who do not have health insurance (or similar) coverage and/or for patients whose only health coverage is Medicaid, NDMS will pay 110% of the Medicare payment amount that would be applicable to the services provided at the time of the public health emergency.

C. For patients with health insurance or health program coverage (other than Medicaid), the health insurer or health program will be the primary payer. For patients other than Medicare or TRICARE beneficiaries, NDMS will pay the difference, if any, between the amount paid by the health insurance coverage and the amount payable under paragraph B above, not including the deductible amount and other cost sharing under the health insurance or health program coverage.

D. For patients eligible for military health coverage (i.e., TRICARE) payment will be made under TRICARE according to the applicable payment rates and procedures, as set forth in 32 C.F.R. Part 199.

E. NDMS payment will end when one of the following occurs, whichever comes first: completion of medically indicated treatment (maximum of 30 days); voluntary refusal of care; return home or to point of origin/fiscally comparable location or to destination of choice for patient (whichever costs less).

6. POINTS OF CONTACT

A. For the NDMS Partners _____

B. For the Provider _____

7. OTHER PROVISIONS

A. Notwithstanding anything in this Agreement, each of the NDMS Federal Partners and the Provider shall have the exclusive authority to direct its employees and to implement its own statutory responsibilities.

B. Nothing in this Agreement is intended to conflict with current federal or state law, or the regulations or directives of the NDMS Federal Partners or the Provider. If a term of this Agreement is inconsistent with such authority, then that term shall be invalid, but the remaining terms and conditions of this Agreement shall remain in full force and effect.

8. EFFECTIVE DATE

This Agreement shall become effective upon signature of one of the NDMS Federal Partners and the Provider.

9. TERMINATION

The Provider or any of the NDMS Federal Partners may withdraw from this Agreement upon 90 days notice in writing to the other parties.

For the National Disaster Medical System For the_____

Printed Name_____ Printed Name_____

Signature_____ Signature_____

Date: _____ Date:_____

Appendix 4: Tier I Hospital Capabilities

The table below summarizes Missouri Tier I Hospital capabilities. For additional information, see Hospital Tier Structure and Recommended Criteria developed by the Missouri Department of Health and Senior Services (DHSS) Dated March 2004.

Tier	Biologic	Chemical	Radiological/Nuclear	ICS/Communication
Emergency Preparedness Tier 1*	Able to triage and hospitalize all classes of infectious patients, including the needs of adults, pediatrics, and other special needs populations, with augmentation plans during epidemic. **Planning Goal**: Admit/Cohort 60 patients with airborne precautions. 30 critical.	Maintains PPE for personnel as determined by OSHA guidelines (see Exhibit 2) and regional plans, able to decontaminate >50 pts per hour, 24/7 with call in of additional staff. Maintain capability to treat all classes of chemically contaminated patients, including adults, pediatrics and other special needs populations. **Planning Goal**: 500 persons (plan supplemental assist for above this number).	G-M counters and safety equipment (badges, etc) available to trained in-house staff 24/7. Radiation Safety Officer or health physicist consultation internally available 24/7. Potassium Iodine tablets available to providers. **Planning Goal**: Screen and provide prophylaxis for 500 persons.	HEICS incident command management system in place within the facility. Communication capability with hospitals within a defined region, EMS, and Region/County Emergency Operations Center required. Current mutual aid agreement or referral plan with other facilities within the defined region. **Planning Goal**: Be prepared to triage/screen casualties based on 500 casualties per 1 million surge population.

CORE CAPABILITY
See Exhibit 1 for recommended stock items and:
- Triage tags, numbered
- Rapid assessment sheets for walking wounded
- Consider additional burn supplies (e.g.: burn sheets, specialized dressings)
- Assure adequate bag-valve and endotracheal tubes to provide for anticipated numbers of victims that may require temporary hand ventilation (e.g.: consider minimum 20-30 bag/valves for Level 1, etc)
- Consider 3-5d supply (based on usual use) of those supplies on formulary lists applicable to your institution

BIOLOGIC
- Adequate supplies of N95 and barrier precautions to protect ED/other clinic staff and staff to care for up to 60 cohorted patients hospitalized for 72h. Assume masks may be used for duration of shift, barrier gowns and gloves disposed of unless working in cohort care area.
- Surgical masks for patients
- Supplies to fit-test additional employees if rapid program required implementing N95 protection
- Doxycycline sufficient to prophylax all at-risk hospital employees and patients for 72 hours
- Consider additional antibiotics, antivirals, suspension preparations, etc. including pediatric considerations

OTHER
- Satellite phone, radio equipment to assure redundancy of critical communication capability
- Vests, clipboards, portable radios, and other HEICS equipment
- EOC equipment including computer access, fax, additional phone lines, phones, etc.

Transport ventilators and portable monitors may be considered but are not a priority of grant funding. Available equipment from crash carts, etc. should be inventoried and used during a disaster.

CHEMICAL
- Stock crystalline atropine and 2PAM adequate to care for 500 victims at 2g/pt 2PAM and 5mg/pt atropine and have compounding protocols available
- Stock Mark 1 kits and ready-for-use atropine and 2PAM for adults and pediatric patients
- Stock sodium thiosulfate adequate for 12.5g/pt for 100-250 victims
- Stock sodium thiosulfate adequate for 12.5g/pt for 100-250 victims
- Five (5) vials sodium nitrite
- Consider stocking additional sodium nitrite (especially as crystalline)
- Consider additional supplies of proparacaine, benzodiazepines, paralytics
- Stock bag-valve devices (15% of total victim number) in addition to usual supplies (see above trauma guidelines)
- Stock additional 7.5 and 7.0 endotracheal tubes (15% of total victim number), consider additional pediatric tubes
- Stock additional oxygen tubing and masks as per trauma
- Chemical PPE 8-12 sets and trained staff 24/7 with augmentation from call-in or outside support within 20 minutes (operations level) (Breathe-easy PAPR with FR57 canister, Tyvek SL or Tychem F suit, booties and gloves, taped seams)
- Decontamination facilities sufficient for 50 pts per hour and associated supplies (e.g.: towels, belongings bags, gowns, etc) (at least 5 shower stations at 1 person / 6 minutes)

RADIOLOGICAL/NUCLEAR
- 3-4 G-M counters similar to Ludlum Model 3 with pancake probe and mR/h scale
- Radiation dosimeter badges for all staff involved in assessment and decontamination
- Consider other forms of dosimetry
- Consider passive screening devices at entryways of high-risk facilities

Potassium Iodine tabs or SSKI to treat 500 victims for at least 24h (2x 130mg tab qd or several qft SSKI adults)

* Criteria may be met by individual hospitals or collectively among hospitals within a defined region that together meet the defined criteria.

Appendix 5: Ambulatory Surgery Centers and Federally Qualified Health Centers

Federally Qualified Health Centers

Swope Health Services
3801 Blue Parkway
Kansas City, MO. 64130
Phone: (816) 923-5800
Fax: (816) 923-9210
bhatches@swopehealth.org
Website: www.swopehealth.org

Swope Health Quindaro 2726 Brown Avenue Kansas City, KS 66104 Phone: (913) 321-2200 Fax: (816) 448-2901 Wyandotte County Curtis Franklin Lodge 3860 East 60th Street Kansas City, MO 64130 Phone: (816) 349-3531 Fax: (816) 448-2906 Jackson County Swope Health Wyandotte 1029 North 32nd Street Kansas City, KS 66102 Phone: (816) 922-7600 Fax: (816) 448-2904 Wyandotte County Swope Health Wyandotte Dental Services Bethany Medical Building 21 North 12th Street, Suite 400 Kansas City, KS 66102 Phone: (816) 922-7600 Wyandotte County	SHC Imani House Residential Substance Abuse & Treatment Center Phone: (816) 929-2600 Fax: (816) 929-2633 *and* SHC Harris House, Group Home for Chronically Mental Ill Phone: (816) 929-2600 Fax: (816) 448-2906 3859 East 59th Street Kansas City, MO 64130 Jackson County Swope Health Northland Health & Dental Clinic 3526 N.E. Vivion Road Kansas City, MO 64119 Phone: (816) 627-2050 Fax: (816) 448-2907 Clay County Swope Health Independence 1638 West US Highway 24 Independence, MO 64050 Phone: (816) 627-2000 Fax: (816) 448-2925 Jackson County

Samuel U. Rodgers Community Health Center 825 Euclid
Kansas City, MO. 64124
Phone: (816) 474-4920
Fax: (816) 474-6475
hfuentes@rodgershealth.org
Website: www.rodgershealth.org

Rodgers Health Center South 2701 East 31st Street Kansas City, MO 64127 Phone: (816) 861-7070 Fax: (816) 861-5087 Jackson County, MO Samuel U. Rodgers Adult Day Care Center 2105 East 7th Street Kansas City, MO 64124 Phone: (816) 924-1414 Jackson County, MO Rodgers Lafayette Health Center Rodgers Lafayette Dental Clinic 721 South 13th Highway Lexington, MO 64067 Phone: (660) 259-3823 Fax: (660) 259-4486 Lafayette County, MO Samuel U. Rodgers Community Health Center Platte County Health Department 4443 NW Gateway Riverside, MO 64150 Phone: (816) 858-2412 Platte County, MO	Samuel U. Rodgers Community Health Center Platte County Health Department 212 Marshall Road Platte City, MO 64079 Phone: (816) 858-2412 Platte County, MO Kansas City Free Clinic 2 East 39th Street Kansas City, MO 64111 Phone: (816) 753-5144 Jackson County, MO Rodgers Independence Dental Center 620 West 23rd Independence, MO 64055 Phone: (816) 254-3382 Jackson County, MO

Other Federally Qualified Health Centers

St. Vincent Clinic 422 Walnut St Leavenworth, KS 66048 Phone: (913) 651-8860 Fax: (913) 682-4409 saintvincentclinic@kc.rr.com Leavenworth County, KS Duchesne Clinic 636 Tauromee Kansas City, KS 66101 Phone: (913) 321-2626 Fax: (913) 321-2651 duchesne@kc.rr.com Wyandotte County, KS	Douglas Community Health Center 1029 N 32nd St Kansas City, KS 66102 Phone: (816) 922-7600 Fax: (913) 371-6001 Wyandotte County, KS Health Partnership Clinic of Johnson County 8600 W 95th St, Ste 100 Overland Park, KS 66212 Phone: (913) 648-2266 Fax: (913) 648-1787 hpjcopks@crn.org Johnson County, Kansas

Ambulatory Surgery Centers

There are fifty-two (52) Ambulatory Surgery Centers (ASCs) in Kansas and seventy-four ASCs (74) in Missouri. For current ASC locations, contact:

Kansas
Kansas Association of Ambulatory Surgery Centers
c/o Wichita Clinic
1947 Founders' Circle
Wichita, KS 67206
Contact: Michele Le Gate
Phone: (316) 613-4947
Email: LeGateMY@wichitaclinic.com

Missouri
Missouri Ambulatory Surgery Center Association
PO Box 6966
Lee's Summit, MO 64064-6966
Contact: Jill Watson
Phone: (816) 246-8680
Fax: (816) 554-4780
Email: masca@sbcglobal.net

Appendix 6: Local DMAT Resources

The table below summarizes local Disaster Medical Assistance Team (DMAT) capabilities.

RESOURCE:	Disaster Medical Assistance Team (DMAT)—Basic					
CATEGORY:	Health & Medical (ESF #8)			KIND:	Team	
MINIMUM CAPABILITIES:		TYPE I	TYPE II	TYPE III	TYPE IV	OTHER
COMPONENT	METRIC					
Team See Note 1	Patient-care Capabilities	Same as Type II	Triage and treat up to 250 patients per day for up to 3 days without resupply	Augment or supplement Type I or II team within this team's local area	Personnel may be used to supplement other teams	
Team Readiness	Roster Fulfillment, Equipment Loading	Upon alert, full 35-person roster within 4 hrs. After activation, deployment ready within 6 hrs	Upon alert, full roster within 6 hrs. After activation, deployment ready within 12 hrs	Upon alert, 75% rostered within 12 hrs. After activation, deployment ready within 24 hrs	Does not meet minimal deployable team requirements	
Demonstrated Readiness	Readiness Testing and Deployment History	Same as Type II plus: History of prior full deployment to austere environment	100% rating on NDMS readiness test in past 12 mos	75% or greater rating on NDMS readiness test in past 12 mos	Less than Type III	
Personnel See Note 2	Membership Level	105 or more deployable team personnel on NDMS roster 12 or more physicians; 3 or more of each of PA or NP, RN, RPh, and paramedic	90 or more deployable team personnel on NDMS roster 9 or more physicians; 3 or more of each of PA or NP, RN, RPh, and paramedic	50 or more deployable team personnel on NDMS roster 6 or more physicians; 2 or more of each of PA or NP, RN, RPh, and paramedic	Less than Type III	
Equipment and Supplies	Logistics Status	Same as Type II	Full DMAT equipment cache properly managed, stored and inventoried per NDMS requirements	Full or partial DMAT equipment cache properly managed, stored, and inventoried per NDMS requirements	Less than partial cache	
Vehicle	Transportation Status	Same as Type II	Pre-arrangement for obtaining primary and alternate use vehicles	Incomplete transportation arrangements	None	
Didactic Training	Basic (Core) and Advanced Training Modules	90% completion of NDMS basic core training plus 50% of advanced training modules (By 08/05)	80% completion of NDMS basic core training plus 25% of advanced training modules (By 08/05)	50% completion of NDMS basic core training plus 25% of advanced training modules (By 08/05)	Less than Type III	

RESOURCE:	Disaster Medical Assistance Team (DMAT)—Basic					
CATEGORY:	Health & Medical (ESF #8)			KIND:	Team	
MINIMUM CAPABILITIES:		TYPE I	TYPE II	TYPE III	TYPE IV	OTHER
COMPONENT	METRIC					
Training experience	Field Exercises (FEXs)	Same as Type II	Participate in at least 2 NDMS approved FEXs, one observed	Participate in at least 1 NDMS approved FEX	N/A	
COMMENTS:	Definition: A DMAT is a volunteer group of medical and nonmedical individuals, usually from the same State or region of a State, who have formed a response team under the guidance of the National Disaster Medical System, or under similar State or local auspices. **Note 1:** Type I = fully operational; Type II = operational ; Type III = augmentation/local team; Type IV = developmental. **Note 2:** Standard DMAT deploys with 35 personnel for all missions. Personnel include a mix of physicians, nurses (RN), nurse practitioners (NP), physicians' assistants (PA), pharmacists (RPh), emergency medical technicians (EMT), other allied health professionals, and support staff.					

2014

BI-STATE

KANSAS CITY REGION

ESF 8 ATTACHMENT K

ATTACHMENT K:

EMSystems Protocols and Policies Manual

ATTACHMENT K. EMSYSTEM PROTOCOL AND POLICIES MANUAL

[This attachment is currently being updated, and will be included for inclusion upon completion]

MID-AMERICA REGIONAL COUNCIL

EMERGENCY RESCUE COMMITTEE (MARCER)

EMSYSTEM PROTOCOLS AND POLICIES

2015

2014

BI-STATE

KANSAS CITY REGION

ESF 8 ATTACHMENT L

ATTACHMENT L:

Hospital Closed Point-of-Dispensing Plan for Medical Countermeasures

ATTACHMENT L. HOSPITAL CLOSED POINT-OF-DISPENDING (POD) TEMPLATE FOR MEDICAL COUNTERMEASURE

I. How to Use this Plan/Template?

This plan has been created to meet the needs of most hospitals in the Kansas City area. As you know, there are plans for dispensing medical countermeasures that differ somewhat across jurisdictions. This may alter the internal plans and procedures for hospitals (i.e. receipt of SNS assets). Attention has been paid to write the sections of this plan so they apply to most hospitals. You may have more specific information you wish to include in some sections to make the plan more helpful for your organization.

All regular text in this plan can be retained, removed or modified as need. This template is meant to assist you in writing a dispensing plan that meets the needs of your organization. Review this plan carefully and modify it as necessary to match your facility's specific needs. Ensure what is written correlates with your EOP and your MOU (or planning) with your local public health department.

Choose language that makes sense based on your procedures, roles, etc. For example, the POD staff positions at your facility may be slightly different than the ones provided here. Update the position names in the plan to correlate with those used at your facility.
Replace **<<Name of Hospital>>** with your facility's name. This has been bolded throughout the plan for easy reference.

Some **bolded** notes have been added that offer suggestions to improve the plan. For example, if procedures differ in Kansas and Missouri, both have been included with a note to only retain the applicable information for your hospital. Remove these instructional notes when finalizing this plan.

Hospital Closed Point-of-Dispensing (POD) Plan Template for Medical Countermeasures

July 31, 2013

Prepared for:
Regional Homeland Security Coordinating Committee's Hospital Subcommittee

II. Revision Tracking Log

REVISION MADE	DATE	CHANGE MADE BY

III. Acronyms

CDC	Centers for Disease Control and Prevention
CEO	Chief Executive Officer
CRI	Cities Readiness Initiative
DHSS	Missouri Department of Health and Senior Services
DOC	Department Operation Center
EOC	Emergency Operations Center
EOP	Emergency Operation Plan
ESF	Emergency Support Function
FAQs	Frequently Asked Questions
HAN	Health Alert Network
HCC	Hospital Command Center
HICS	Hospital Incident Command System
IC	Incident Commander
ICS	Incident Command System
IT	Information Technology
KDHE	Kansas Department of Health and the Environment
KHERF	Kansas Hospital Education and Research Foundation
KS-CRA	Kansas Countermeasure Response Administration
MARC	Mid-America Regional Council
MCM	Medical Countermeasures
MOHSAIC	Missouri Health Strategic Architectures and Information Cooperative
PIO	Public Information Officer
POD	Point of Dispensing
PPE	Personal Protective Equipment
RSS	Receipt, Storage and Staging Site
SNS	Strategic National Stockpile
URL	Uniform Resource Locator (web address)

IV. Introduction

A. Background

The purpose of this Closed Point of Dispensing (POD) Plan (referred to herein as POD PLAN) is to coordinate the planning and response actions of <<Name of Hospital>> during a public health emergency requiring medical countermeasures (usually oral medication or vaccinations) given to a group of people at risk of exposure to a disease.

This plan provides the framework for activating and operating a POD within the hospital. This plan is intended to identify key roles in POD activities and outline strategies for coordinating internal response activities.

> ***"Medical Countermeasure dispensing*** is the ability to provide medical countermeasures (including vaccines, antiviral drugs, antibiotics, antitoxin, etc.) in support of treatment or prophylaxis (oral or vaccination) to an identified population in accordance with public health guidelines and/or recommendations."
> - CDC's Public Health Preparedness Capabilities, March 2011

The goal of a POD site is to provide prophylaxis or vaccinations to hospital employees and others in a coordinated, orderly and efficient manner to help slow or stop the spread of disease within the community. Often the hospital's POD will be part of a larger community-wide effort to provide medical countermeasures to the necessary people within 48 hours of identification of the public health emergency. In some cases (i.e. bioterrorism or pandemic), the entire population may require medications or vaccine.

The POD PLAN is not intended to serve as stand-alone document but rather supplement the hospital's Emergency Operations Plan (EOP). The EOP outlines the ways in which the hospital departments will coordinate during an emergency to respond to various scenarios using the Hospital Incident Command System (HICS). This POD PLAN provides greater detail on hospital's response activities and internal coordination efforts specific to the dispensing of medical countermeasures to prevent the spread of disease.

This document has been developed through a planning process that included meetings with hospitals and public health agencies throughout the Kansas City metropolitan area and a review of existing plans, protocols and procedures. It is expected that this plan will continue to be refined and updated on an annual basis at minimum.

B. Situation

The hospital will operate their "Closed" POD at the same time the community is dealing with a significant public health emergency. A "Closed" POD is one that dispenses medication or vaccinations to a pre-identified segment of the population (i.e. hospital employees and families) and is not open to the general public.
The hospital will be busy with numerous response activities as "first receivers" of potential victims and, likely, worried well. Whether caused by bioterrorism, pandemic disease outbreak or other type of disaster, the hospital's resources will be stretched to support its response. During this time, hospitals may be involved in the following components of the event's response:

1. Care for employees – in a crisis, the safety and well-being of staff members are crucial to a facility's ability to maintain its primary mission of providing care to the community it serves.

2. Surveillance – being aware of signs and symptoms of the possible use of biological, chemical, radioactive or nuclear agents can lead to early diagnosis. Treatment can be started sooner, and unexposed individuals can be protected.
3. Treating patients – depending on the nature of the disaster, healthcare facilities and personnel may need to treat large numbers of patients for injury/illness. This medical surge event may overwhelm the facility's capacity to care for those seeking assistance. They may also need to treat patients for exposure to various biological, chemical, radioactive or nuclear agents.
4. Preventing the spread of disease – measures to prevent the spread of disease could include the use of vaccines and other prophylactic agents, as well as non-pharmaceutical interventions such as engineering controls and personal protective equipment (PPE). Social distancing strategies may also be employed to prevent the spread of disease.
5. Establishing a POD to quickly provide medical countermeasures to first receivers – employees, physicians and/or other support personnel – will help prevent exposures to certain biological agents.
6. Providing mental health services – any disease may be extremely stressful to patients, employees and other members of the community. Volunteers may be needed to provide needed mental health services.
7. Assessing medical resources- assess the need for additional medications, medical supplies and services.

During an event where medical countermeasures are to be distributed to large groups or to the entire population, the local public health department will operate "Open" PODs. These PODs are open to the public and are designed to process people through the site efficiently to get medications or vaccinations to the most people as quickly as possible. In an event involving the entire population, long lines are expected at the Open POD sites. To alleviate some of the demand on Open PODs, state and local health departments have identified key facilities in their communities that could provide countermeasures to large numbers of people.

Hospitals have been recognized not only because they often have a large number of employees, but also because they provide critical services that need to be maintained during a response. Public health departments have engaged hospitals in pre-planning so that hospitals can operate as Closed PODs. Hospitals will set up a POD site to dispense countermeasures to a designated population. Several hospitals have mutual aid agreements with their local health departments; others have been planning cooperatively on this issue for several years and know how coordination between the organizations will occur.

B. Assumptions

There are many variables that will impact Closed POD operations. For the purposes of this plan, specific assumptions have been made to document roles, responsibilities, considerations and critical functions. During a public health event, the hospital will be receiving information from the Centers for Disease Control and Prevention (CDC), state and local health departments, and other sources that will provide hospital officials with information to make informed decisions that may deviate from this plan.

This plan is created to help hospital employees understand a POD operation conceptually and to document plans as they exist in the absence of specific event information. There will be changes to the procedures and expected actions outlined here based on the event-specific information hospital leadership receives at the time.

C. The following are a list of assumptions on which this plan is based.

1. There is a suspected bioterrorism release in the area. Based on early investigation, the nature of the suspected agent and its release will require the entire population to receive medical countermeasures. This plan is written based on an Anthrax release requiring prophylactic Doxycycline or Ciprofloxacin for most people.
2. For the purposes of this plan, oral medication will be dispensed. (For those diseases where vaccinations are indicated, the POD set-up will change and number of staff required will increase because every individual must come through the POD. With oral medications, one family member may pick up their entire family's medications limiting the number of people through the POD (commonly referred to as the Head of Household model.)
3. As soon as the hospital is notified/identifies that a public health emergency has occurred, the Hospital Command Center (HCC) is activated and the Hospital Incident Command System (HICS) is used. The HCC will be active for the entire time the POD is dispensing.
4. The hospital will receive official notification of the need for a Closed POD from their local public health department.
5. The hospital will activate other aspects of their EOP at the same time as the POD operation. Handling an influx of patients, setting up a labor pool and managing limited resources will all be competing concerns for the Incident Commander and staff.
6. **<<Name of Hospital>>** and hospital staff will coordinate closely with public health officials and other response partners to implement mass prophylaxis, vaccination or treatment actions.
7. Equipment, supplies, medications and other resources may become limited during this event. The hospital may request resources from various sources including their regular suppliers, parent corporation (if applicable), the health department or Emergency Operations Center in its jurisdiction, the Regional Healthcare Coordination System, etc.
8. Multiple approaches to disease control, beyond mass prophylaxis, vaccination and treatment, may be necessary. Federal guidance about which groups have priority access to medicines and vaccines that the CDC provides, either directly or indirectly, will change with different scenarios.
9. Guidance will be updated throughout the event. The hospital may not have real-time situational awareness at all times. For example, diagnosis, investigations and confirmatory lab testing all take time. However, the balance of time versus safety may shift toward rapid interventions to limit exposure to a disease.
10. Depending on the illness, mode of transmission and availability of medical countermeasures, mass prophylaxis, vaccination or treatment may not be indicated or feasible.
11. The hospital's response will be of interest to the media. Hospital officials will be required to deliver messages regarding the emergency's impact to the hospital and the hospital's response activities.

V. Pre-event Planning

A. Determine Dispensing Population

Determining the total number of people the hospital expects to serve at the POD is a critical step in the planning process. This number will help define the dispensing strategy for the organization by helping determine the size, location and layout of the POD; the number of staff needed to operate the POD; as well as the timeline for dispensing the medication.

The dispensing plan will depend on the nature, type of agent (suspected or confirmed) and mode of transmission in a biologic event. Also, it will depend on the amount of drugs available for distribution. Assuming that the event requires medical countermeasures for the entire population, **<<Name of Hospital>>** estimates the number of regimens (that is, total number of courses of treatment) required for the POD for planning purposes.

Prior to an event, hospital leadership will have considered the groups of people they will likely serve with their POD. Each additional group increases the demand on POD staff and resources, but is appropriate in helping to minimize risk and may provide emotional support at a stressful time (i.e. including family members of employees). This is a policy decision and will likely differ between individual hospitals. This planning figure is shared with the local public health department to provide an estimate of the number of people who will be served via the hospital's POD.

(Information exists to help the hospital estimate its dispensing population. Census data is available for each county and household members can be estimated based on that figure. Go to U.S. Census Quick Facts to obtain an exact number per household to use as a multiplier. http://quickfacts.census.gov/qfd/index.html

Because employees may not reside in the county in which the hospital is located, this figure may not be correct. Hospital advisers to this plan recommend estimating high to ensure adequate supply of medications. The suggested minimum multiplier is 2.5 shown below. Based on county data, the regional average is 2.56.)

(The chart below includes employees, their household members, patients and their families. Update this chart to reflect your hospital's identified populations.)

POPULATION	NUMBER OF REGIMENS
A. Number of Employees (include full- and part-time employees, physicians, volunteers, students, etc.)	**1,200**
B. Planning Factor to accommodate household members of employees listed above *(Number of employees x 2.5 household members)*:	**3,000**
C. Patients (based on average census)	**110**
D. Planning Factor to accommodate families of patients *(Number of patients x 2.5 household members)*:	**275**
Total Estimated Regimens Required (B+D):	**3,275**

Estimating Dispensing Population

These estimates may change at the time of an event. The hospital will update/confirm the calculation prior to requesting resources from the Strategic National Stockpile (SNS).

B. Priority Plan for Prophylaxis

Access to the medical countermeasures needed may be limited especially in the initial phases of an event. The hospital will identify multiple strategies to obtain medications to provide prophylaxis to the groups identified above (See Section 4 for more information).

<<Name of Hospital>> has identified a prioritized approach for dispensing at the POD to promote continuity of the hospital's critical operations by providing medication to those at highest risk of exposure first. This is intended to be a guideline for hospital leadership (i.e. Medical/Technical Specialist) who will confirm this approach at the time of the event.
During an event, local, state and federal guidance may be released to identify the priority order of personnel to receive available drugs for prophylaxis. This plan will be modified to comply with these recommendations as appropriate.

(Have this discussion internally and decide the priority order for your facility. A first-come, first-served approach could also be used. Update this section to reflect decisions made.)

First Tier:

Hospital emergency response personnel. This will include those employees and physicians working in the Emergency Department and those staffing the POD. POD staff should receive medications prior to the opening of the POD for other groups. Because of the nature of a biological incident, pharmacy, laboratory and Hospital Incident Command Center staff should be included as well. *Patients with previous exposure or probable exposure.* This determination will be based on the best epidemiological evidence at the time.

Second Tier:

Healthcare workers who directly care for patients. This is defined as the worker that is physically caring for patients and those individuals who have a history of exposure to an infected patient, not just the sharing of air space. Examples include nurses, physicians, respiratory therapists, patient care technicians, etc.

Third Tier:

Healthcare workers who support the direct care of patients. Examples include chaplains, admitting staff, social workers, patient advocates, nutritional services, environmental services, etc.

All Others:

This includes remaining hospitalized patients (if necessary), employees, volunteers and family members.

VI. Organization and Responsibilities

A. Coordination with Public Health – Roles and Responsibilities

LOCAL PUBLIC HEALTH DEPT WILL:	(HOSPITAL NAME) WILL:
▪ Provide planning and technical assistance in gathering information and providing guidance to meet the hospital's specific needs. ▪ Provide a Point of Contact with primary and back-up methods of communication and update information accordingly. ▪ Document any and all information necessary in the health department's Closed Site Dispensing Plan and notify all Closed Sites of any changes, updates, modifications, etc. ▪ Provide proper trainings on processes and systems (i.e. Mass Prophylaxis Dispensing, Dispense Assist, and WebEOC). ▪ Share information with hospital on standing orders, medical protocols and directives including dosing, follow-up procedures, and releasable information consistent with state and federal guidelines. ▪ Coordinate with hospital to request and transport SNS assets. ▪ Provide necessary paperwork, such as Medical Screening forms, medication information sheets, FAQs, etc. and access to online resources for systems that may be used (i.e. Dispense Assist, WebEOC).	▪ Request medications according to the number of individuals identified by facility's plan. ▪ Provide a Point of Contact with primary and back-up methods of communication and update information accordingly. ▪ Participate in planning meetings, trainings, and exercises of dispensing site plan. ▪ Assume responsibility of dispensing medications to those individuals identified above by the hospital's trained staff at a site chosen by the hospital. ▪ Coordinate with Health Department to request and transport SNS assets. ▪ Monitor medical screening and medication recommendations based on local, state, or federal standing orders and guidelines. ▪ Provide medications and administration free of charge except as permitted by the state or by CDC. ▪ Complete and submit all requested documentation (inventory records, etc.) during a public health emergency. ▪ Notify the health department of any changes or modifications to the Hospital's POD Plan.

B. POD Staffing

The POD will likely be open 24 hours each day until all targeted individuals have received medications (See Section 2 for dispensing population). Staffing the POD may take away resources from some day-to-day activities. HCC staff will determine which less critical functions can be curtailed during POD operation.

The number of staff required for POD operation will depend on the size and layout of the room, the designated populations, throughput and time allotted for dispensing operations. The staffing model is scalable and can be expanded or contracted to meet demands. Key positions are identified below. In a large POD, some positions will be duplicated as several lines would be established (i.e. multiple dispensers). Job Action Sheets for individual positions are in an accompanying file.

(Change the list of staff below to reflect the nomenclature used by your hospital.)

Management

POD Manager. The POD Manager is responsible for overall POD operations and serves as the primary connection back to the Hospital Command Center. This position assigns staff to all other positions in the POD.

Health and Safety Officer. The Safety Officer ensures POD operations are carried out safely with careful attention to details in the POD set-up and surrounding environment. This person also monitors POD staff for signs of fatigue or distress and encourages support of staff's needs.

Clinical Care Unit Leader. This position supervises staff with clinical responsibilities including triage, medical screening, evaluation and dispensing. The Clinical Care Unit Leader reports issues of concern to the POD Manager.

Clerical Support Unit Leader. The Clerical Support Unit Leader supervises administrative staff that help ensure efficient throughput of people. Greeters and other clerical support staff help ensure proper recordkeeping. The Clerical Support Unit Leader reports issues of concern to the POD Manager.

Clinical Care

Triage Leader. This individual coordinates triage process to ensure symptomatic people are identified and transported to treatment area (i.e. emergency department).

Medical Screener/Evaluator. This person reviews health information provided by individuals to determine contraindications and helps to identify appropriate medication according to medical directives and orders.

Dispenser. This position provides accurate dispensing of medications to POD clients in a timely and efficient manner.

Clerical Support

Clerical Staff. Personnel provide clerical assistance and assistance with data entry, registration, forms completion and other support as needed to POD personnel.

Greeter. Greeters provide assistance to those entering the POD. Ask basic triage questions and refer symptomatic individuals for treatment evaluation.

Registration. Staff working the registration desk ensure forms are completed for all household members. This function may be combined with the role of the Greeter.

Other Support

Other staff will support the POD effort by performing duties similar to their day-to-day job responsibilities. This includes Information Technology (IT) support staff and security personnel.

These positions will receive direction from the POD Manager (or designee). Runners may also be used to perform quick, discrete tasks that assist with POD operations.

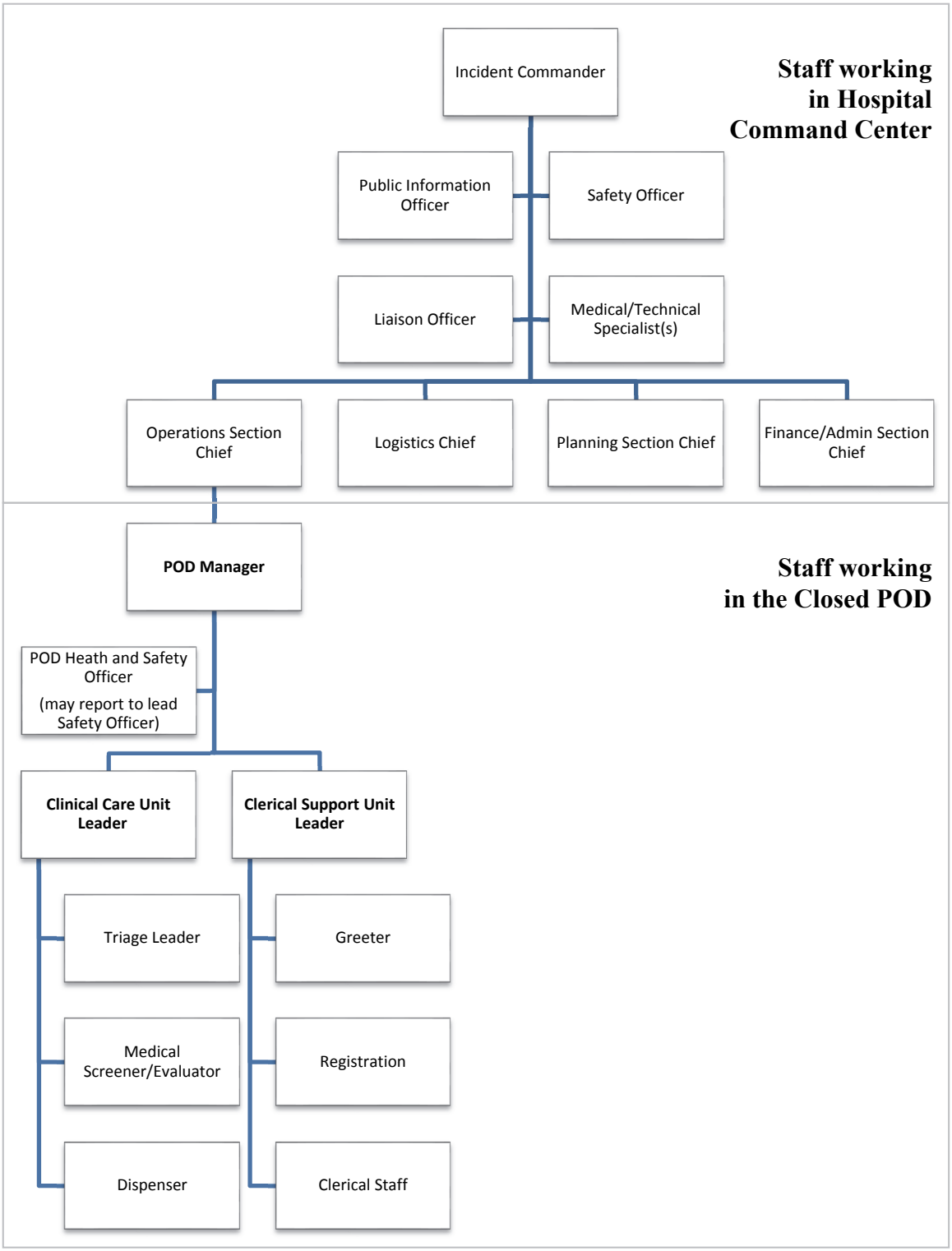
Other staff positions within the Hospital Incident Command System may support POD operations as directed by command staff.

C. Integration with HICS

POD staff work under the Hospital Incident Command System. The POD Manager reports directly to the Operations Section Chief stationed in the Hospital Command Center. All sections of the HICS will be supporting POD operations.

Job responsibilities for each position in the POD include working within this command structure. The structure helps clarify responsibilities and expectations for each staff member and helps keep the scope of each position discrete and manageable. A HICS flow chart shows the relationship between the POD staff and the Hospital Command Staff.

Figure 1. Incident Command Structure



VII. Activation of Closed POD

A. Notification of Need for Closed POD

A local health department representative will contact a hospital official and notify of the need to open a Closed POD. This communication will occur by phone to the primary contacts on file with the health department. The call will come in to the following people:

Hospital Contacts for Notification of Need for Pod

Primary Hospital Contact		Secondary Hospital Contact	
Name/Title:		Name/Title:	
Phone Number:		Phone Number:	
Back-up phone number:		Back-up phone number:	
Hospital 24-hour number:			

The hospital representative receiving the request will communicate the need to open the POD to the Incident Commander (if the HCC is already activated) or the Administrator on Call. The CEO will be notified of the request from the health department to open a POD. The CEO (or designee) will give the IC authorization to initiate POD operations.

After approval from the CEO (or designee), the employees identified as POD management staff will be notified of need to report for POD set-up. This team (as outlined in Section 3) will be notified by phone, page and/or email to report to the **<<Name of location to report>>** for further instructions. The Operations Section Chief in the HCC will assign roles to individuals and determine what resources are required for initial POD set-up. A POD Manager will be assigned and will assume leadership of POD functions.

Employees will receive notification of the POD operations and need for medical countermeasures as outlined in the Communications Plan (Section 6 below).

B. Medication and Materiels

Accessing Medications for POD Use
One of the first priorities of the hospital command staff will be to access pharmaceuticals that have been identified for prophylactic use against the suspected (or confirmed) biological agent. For an anthrax scenario, hospitals primarily need Ciprofloxacin and Doxycycline. There are several potential sources for these medications, but likely a fairly limited supply will be immediately available.

Current Hospital Inventory. Hospital pharmacies may have some doses of the medications available, but in extremely limited supply. HCC staff should work with the pharmacy staff to understand how much may be available "in-house."

Corporate Warehouse. Some hospitals in the metropolitan area have access to a warehouse of supplies, equipment and other resources owned by their parent corporation. Some medications are housed here, but, again, not in the quantity needed for POD operations.

Regional Suppliers. Hospitals have existing relationships with vendors for supplies and pharmaceuticals. Command staff will contact suppliers to place and expedite orders of additional

doses as they are available. This potential source could be problematic as many vendors support several area hospitals. In a large-scale event, hospitals will likely be competing for the same resources.

Pharmaceutical Caches. Area hospitals may have the opportunity to access medications from several different caches available to the region. Caches have been created to help get medications quickly to area first responders and receivers. However, with multiple requests for resources, the deployment of items from the cache must be coordinated within and between jurisdictions. The hospital will contact the local public health department and the Regional Healthcare Coordinator (see page 26 for contact information) at the time of an event to find out about the possibility of accessing cached resources. In preparedness, the hospital will have discussions with these community partners about what support to expect (if any) from existing pharmaceutical caches. (This information should be updated annually as financial constraints may decrease cache size over time.) More information about regional caches will be included in the Regional Coordination Guide: Emergency Support Function #8 – Health and Medical section to be developed in 2013.

POTENTIAL SOURCE FOR MEDS	HOW TO CONTACT
Hospital Pharmacy	24/7 phone number (If the number is not answered 24 hours a day, please provide a back-up number.)
Corporate Support	24/7 phone; email (If the number is not answered 24 hours a day, please provide a back-up number.)
Vendor Supply	24/7 phone number for rush orders; email (If the number is not answered 24 hours a day, please provide a back-up number.)
Pharmaceutical Cache	24/7 phone number for Public Health contact and Regional Healthcare Coordinator; email (If the number is not answered 24 hours a day, please provide a back-up number.)

It will become clear quickly that the hospital needs more medications and supplies than it can plan to receive from the local sources described above. The Strategic National Stockpile (SNS) managed by the CDC has medications, supplies and equipment available to hospitals, health departments and other entities when locally available quantities are no longer sufficient.

C. Accessing SNS Materiels

The SNS has large quantities of medicine and medical supplies to protect the public if there is a public health emergency (i.e. terrorist attack, flu outbreak or earthquake) severe enough to cause local supplies to run out. Once local, state and federal authorities agree the SNS is needed, portions of the SNS will be deployed and made available locally. There is a 12-hour "push" package that can be deployed rapidly. Plans exist within state and local health departments to receive the medications and supplies from the SNS and distribute them to dispensing sites and healthcare facilities as needed.

Ordering SNS Meds and Materiels
The hospital will request SNS assets in accordance with its state and local health departments' procedures. The hospital command staff will work to identify what medications should be

requested. Because this scenario will also involve a medical surge event, medical equipment and supplies may also be ordered.

(The ordering process differs depending on what state and local health department jurisdiction a hospital is in. Select the description that is accurate for your facility and delete others. Also, confirm the process with your public health partners. Plans may change that impact the procedures outlined below.)

In Missouri, hospitals have been designated Closed PODs and have been given the authority to request SNS assets directly from the MO Department of Health and Senior Services (DHSS). Requests are made through MOHSAIC, Missouri's electronic system to manage distribution of SNS inventory.

1. The hospital has designated **<<TITLE OF PERSONNEL>>** to complete the request in MOHSAIC (training and log-in/password is required for this person).

2. An order confirmation will be received via email with information about fulfillment and how, when and where to pick-up the order.

3. Hospital personnel will notify the Local Public Health contact via phone or email that an order has been placed to promote situational awareness.

In the event MOHSAIC is not working, hospitals will use the latest spreadsheet order form and submit the information via fax or email to their local public health department. The hospital should call the health department to confirm receipt of the order. Health Department personnel will then place the order with MO DHSS on the hospital's behalf.

In Clay County, Missouri, hospitals will request SNS medications directly from the Clay County Public Health Center via phone, fax, email or WebEOC. The health department will place the order in MOHSAIC on the hospital's behalf. Note: Hospitals will place their request for equipment and supplies directly in MOHSAIC.

1. The hospital emergency preparedness coordinator will contact the Clay County Public Health Center to place request for SNS medications. Clay County Public Health will complete the order in MOHSAIC placing information in the notes section that the order is for the hospital.

2. The hospital has designated **<<TITLE OF PERSONNEL>>** to complete the request for equipment and supplies in MOHSAIC (training and log-in/password is required for this person).

3. An order confirmation will be received via email with information about fulfillment and how, when and where to pick-up the order.

In Ray County, the Ray County Health Department will order SNS assets in MOHSAIC on behalf of the hospital. It is not necessary for hospital staff to be trained on the MOHSAIC system. Separate orders will be placed so that MO DHSS knows to package the materiels for the hospital and health department separately.

In Kansas, the request for SNS assets is coordinated through county and state EOCs.

1. Hospitals in Leavenworth and Wyandotte counties, submit order forms via email or fax to the County Health Department Operation Center (DOC). (Put contact info here.)

2. The health department submits request to the County EOC (ESF #8 section).

3. The EOC then forwards the request on to the State's ESF #8 Coordinator in the State EOC.

In Johnson County, hospitals submit a "Request for Assistance" via WebEOC. County officials review the request and send it on to the State EOC. If unable to submit the request in WebEOC, hospitals in Johnson County can also email, fax or phone in the information to the Johnson County Department of Health and Environment.

Transport to Closed POD Sites
Once the State health department has readied the hospital's order, the method in which it is transported to the facility differs across the metropolitan area. Armed security escort is required from the Receiving, Storing and Staging, or RSS, site to area hospitals.

(Transporting the SNS assets differs depending on what state and local health department jurisdiction a hospital is in. Select the description that is accurate for your facility and delete others. Also, confirm the process with your public health partners. Plans may change that impact the procedures outlined below.)

In most cases, the public health department will arrange for delivery of the SNS assets to the hospital directly. In Kansas City, Missouri, hospitals will pick up materiels from the RSS site using their own truck, but the City will provide a police escort for the return trip from RSS to hospital. In Jackson County, hospitals will pick up SNS assets from the RSS site using their own truck and armed security escort. Hospitals are encouraged to notify the Jackson County Health Department if arranging armed security is problematic. In Independence, Missouri, the hospital and health department will share resources and pick up materiels from the RSS together using the hospital's truck and city-provided security.

Once the SNS assets arrive at the hospital, hospital officials take responsibility for securing the SNS assets during the entire POD operation. The hospital has designated **<<TITLE OF PERSONNEL>>** to ensure SNS assets are kept in a secure location when not in use.
(If hospital is required to pick up medications from RSS site, describe the resources available for transportation here (for example, box truck with designated driver).)

Resupply During an Event
If the hospital requires additional medications or supplies from the SNS during a prolonged event, the same process is followed as for initial orders described above.

Return of Unused Items
At the conclusion of the event, the hospital should notify their local health department if the hospital has unused SNS medications, supplies or equipment remaining. The CDC will provide guidance on disposition of the materiels and local health departments will provide specific instructions on this process at the time. The hospital will keep assets in a secure location until this decision has been made.

D. POD Set-up

Site Selection

The Closed POD site should meet basic requirements to help make the experience as easy as possible for those going through the POD to receive medications and for those who will work at the POD site. Sites should have heat and air-conditioning to maintain controlled room temperature; adequate bathrooms, water and electricity; a loading area for supplies; adequate parking; separate entrance and exit; and handicap accessibility. When deciding where to place a POD, the hospital should assume they will be dispensing medications to the highest planning number estimated, will likely be doing so on a 24-hour basis until complete and recognize that it is easier to contract than to expand a POD site.

For **<<Name of Hospital>>,** the POD will be located in:

POD Location

POD	BUILDING	ROOM
Primary	Main Facility	Conference Room A/B
Alternate	Medical Office Building	Classroom 3
Second Alternate		

Site Design

The POD is set up in a manner to allow for maximum efficiency. See process flowchart on next page.

Figure 2. POD Process Flowchart

How each station is staffed will have a direct impact on how fast people will be able to move through. A layout of the POD (in the primary location) should be completed in Appendix A.

Signs have been prepared to direct movement of people, keep people moving and to let them know what will happen at each station. Signs will be placed so that they are readily visible (6-8 feet in the air; not taped to tables or floors) during POD set-up. See Sample Signs in accompanying electronic file.

Throughput

POD "throughput" – the number of people processed through the POD within a given time – is based on the designated population, the number of dispensing staff available, dispensing flow and the time available to dispense medication. The hospital will work to maximize throughput without jeopardizing safety of POD staff or clients.

Resources Needed

The checklist below has been identified as the minimal equipment and supply resources to operate a POD. The hospital will acquire items from this list to be available for POD operation (or know how to access items when needed that may have an alternate use).

POD EQUIPMENT AND SUPPLY CHECKLIST

General Supplies and Equipment

- ☐ Tables
- ☐ Chairs
- ☐ Antibacterial hand washing solutions; alcohol based hand hygiene preparations
- ☐ Paper
- ☐ Pens, Pencils
- ☐ Tape
- ☐ Stapler/staples
- ☐ Scissors
- ☐ Self-adhesive notes
- ☐ Clipboards
- ☐ Paper towels
- ☐ Facial tissues
- ☐ Trash bags
- ☐ Bags to carry multiple doses of medications (1 per family)
- ☐ ID Badges for volunteer staff

Communication and Computer Equipment and Supplies

- ☐ Communication: Telephone, Radio and/or cell phone
- ☐ Laptop Computers or tablets
- ☐ Printers
- ☐ Paper
- ☐ Internet Access
- ☐ Back-up batteries, power cords
- ☐ Extension Cords (if necessary)

Vaccine Administration Supplies (if required)

- ☐ Vaccine cooler/refrigerator
- ☐ Sharps containers
- ☐ Latex-free gloves
- ☐ Antibacterial hand washing solutions
- ☐ Acetone
- ☐ Rectangle adhesive bandages
- ☐ Gauze
- ☐ Adhesive tape
- ☐ Spray bottle of bleach solution
- ☐ Hazardous medical waste bags

Crowd Management Supplies

- ☐ Signs for identifying each dispensing site station
- ☐ Directional signs throughout the facility
- ☐ System to keep people in lines
- ☐ Walkie talkie radios

Miscellaneous Supplies

- ☐ Educational handouts regarding medication dispensed
- ☐ Labels for medication and documentation on forms
- ☐ Printed list of phone numbers (e.g. Administration, Security, HCC, etc)
- ☐ Printed directions for technology (i.e. Dispense Assist)
- ☐ Language line

VIII. POD Operations

A. What Happens at a Closed POD?

Individuals arrive at the POD and pass through a series of stations to provide information, receive medical evaluation (if necessary) and, ultimately, receive medications and education specific to the public health emergency. The layout of a POD may vary depending on available staff and how many people are likely to use the POD. Regardless of the specific names and setup of stations, the following process is followed.

Individuals complete a medical screening form. For some hospitals, this form is available electronically and can be completed, printed and brought to the POD. A greeter will ensure the form has been filled out completely and information is included on each household member. Accommodations will be made if forms need to be completed onsite.

Individuals are screened for illness and contraindications to medications In an effort to limit exposure to illness, individuals will be "triaged" to ensure symptomatic people are moved to an initial evaluation area and/or transported to a treatment area (i.e. wellness clinic, emergency department). Similarly, medical screening forms are carefully reviewed to ensure all persons receive the appropriate medications based on their own health histories and medical directives from the CDC. This may require an additional stop at an Evaluation area to consult with a medical provider on which medication is the best alternative.

Individuals receive medication and information. Based on the information provided on the medical screening form and dispensing algorithms, the appropriate medication is provided for each person listed on the medical screening form. Individuals should leave the POD with instructions on how to use medication, fact sheets about the drug and the biological agent, and information on how to report adverse events. Individuals will also be advised to take the first dose right away. Pharmaceutical bags can be used for medication that is being picked up for other family members. After receiving medication, individuals exit the POD.

B. Dispensing Decisions

Guidance and algorithms will be released at the time of the event that provide health departments, hospitals, individual physicians and others with the information they need to determine the appropriate medication for an individual after reviewing the person's medical screening form and noting contraindications and health history. There may be some cases where this decision is not readily clear or where no medication available at the POD is appropriate. The Clinical Care Unit Leader is responsible for seeking input from the Hospital's Medical/Technical Specialist(s) regarding individual cases.

During POD setup, the Hospital Preparedness Coordinator will gather reference materials and related guidance to assist the Medical/Technical Specialists (or designees) with these clinical decisions. Some basic materiels can be gathered in advance (i.e. Category A agent information from the CDC), but the Preparedness Coordinator should confirm they are current when gathering the event-specific information. (For planning guides with background information on several biological agents, go to Disease Planning Guides at https://www.dispenseassist.net/downloads.html)

C. Supporting Individual Needs

Symptomatic People. Coming to a dispensing site and being identified as needing treatment instead of preventive medicine can be a stressful experience. POD staff receives training in how to support individuals in a respectful and appropriate manner. Once identified as symptomatic, individuals will be transported to another area for care – most likely, the emergency department. POD staff will accompany the individual to the treatment area as necessary. Limiting exposure to asymptomatic people at the POD site is also a concern. The POD is setup to separate those that may be ill from the general population as early in the process as possible. The Triage Unit Leader will get approval from the Clinical Care Unit Leader for transport of individuals to treatment areas.

Non-English Speakers. The hospital has employees with limited English language fluency. Certainly, there will also be family members and patients that do not speak English well enough to converse with POD staff and understand medication guidance. The hospital will use its same day-to-day policy on interpretive services. A phone will be available to access a Language Line service to provide interpretation over the phone. The hospital has designated the **<<Clerical Support Unit Leader>>** as the primary support person when a language line is necessary. Forms will be available in other languages upon notification of need (see CDC website). When the health department provides the forms to use, information will be provided on how to access the same forms in other languages. POD staff should be prepared to print forms onsite as needed. **(Explain here the process for accessing and printing appropriate forms and assign responsibility to a POD staff member. Ensure enough time is allocated to print the forms before the opening of the POD.)**

Consideration of Other Needs. There will likely be other needs expressed or situations recognized where individuals need additional support from POD staff. The POD Manager, Clinical Care Unit Leader and Clerical Support Unit Leader will be primarily responsible for problem solving on an as need basis. All POD staff should report concerns or feedback received to their supervisor.

D. Security at POD

Security is an important component of POD operations. Policies and procedures related to hospital security are outlined in other sections of the EOP. The safety and security of POD staff and designated population that will come to the facility, the actual facility and the medications being dispensed is of utmost concern. The **<<TITLE OF PERSONNEL>>** has been tasked with overseeing security for the hospital during the POD operation. Activities to enhance the security of the employees, patients and others may include the following measures:

Physical Security. Preventing unauthorized access to the POD site, facility, and medication.

1. Control the flow of traffic arriving and departing from POD site as well as throughout the POD process.

2. Secure unused entrances and exits.

3. Pre-identify a *secure* location within the facility where medications can be stored until needed. **(List primary and back-up location here.)**

4. Use appropriate signage.

Personnel Protection. Security measures will also be taken to promote the safety of hospital employees and other individuals being served by the POD. Individuals disruptive to the operation of the POD will be removed by security and/or law enforcement personnel. The hospital has

established a process of emergency communications so POD staff can quickly request assistance from security personnel as needed. **(Describe how this will happen here. For example, via 2-way radio, raise flag for security to see, code word not to alarm others, etc.)**

Law Enforcement/EMS. The POD Manager and security personnel have contact information readily available for the local police department in case a security issue should arise that requires intervention by local law enforcement. **(If the plan is to call 9-1-1, state this. If another way to contact, describe here.)**

E. Strategies to Enhance POD Operations

(Keep any of these that apply and provide specifics for your hospital. Delete any that contradict your facility's procedures.)

Dispensing software. Some hospitals plan to use technology systems that help expedite the POD process by creating electronic records with built in algorithms to make the dispensing recommendation automatic. Medical screening and evaluation is needed on many fewer people increasing the efficiency with which people can move through the POD. This technology also allows employees and others to complete the screening forms prior to coming to the POD. This helps alleviate bottlenecks at the entrance to the POD. Another potential advantage of an electronic system is the ability to maintain record and aggregate data in an electronic format rather than hard copy medical screening forms. Dispense Assist is one solution which many hospitals in the area plan to use for POD operations.

Pre-printed medication labels. Current electronic and manual systems for dispensing do not produce medication labels with complete information required on individual bottles of medicine. Bottles from the SNS come with labels on them that provide some information (medication name, dose, lot number, etc.). However, the hospital plans to affix an additional label with the following information:

1. **(Confirm this list with pharmacist)**
2. Hospital name
3. Blank space for name of individual receiving medication to be written in
4. Space for date dispensed
5. Blank space for dispenser to initial

Printing these labels in advance for the most common drugs will help expedite POD setup and dispensing.

IX. Communication Plan

A. Communicating with Employees and their Families

Before an event, the hospital will develop an awareness campaign to inform employees of the hospital's intent to serve as a Closed POD. Key messages will include:

1. What a Closed POD is and why it might be necessary
2. How it protects employees and their families
3. How medication will be dispensed
4. What information they should be prepared to provide at the POD

This information will be shared on the intranet, at staff meetings, annual education fairs, etc.
During an event, hospital leadership shall send communication to all employees.
Communication to staff regarding who is eligible to receive treatment, where and when will be accomplished through:

1. A mass phone message using the notification system
2. Overhead page
3. Intranet
4. E-mail notification and
5. In-person messages relayed through department supervisors/managers.

Communication will include:

1. Identification of the nature of the emergency
2. **<<Name of Hospital's>>** participation as a POD site: medication will be provided to employees during a large-scale public health emergency
3. Plan for dispensing – Basics on how medications will be dispensed to employees and their families including where and when they will receive their medications
4. Information they should bring for all household members to the POD to assist in screening for possible allergies and/or contraindications to make sure each person receives the best antibiotic for him/her
5. Health information, drug allergies, current medication list, current weight (necessary to determine appropriate dose for children)
6. Roles and responsibilities of employees in an emergency
7. Types of preventive measures to be taken

8. General emergency preparedness

9. How they can stay informed (i.e. hospital website, hospital Facebook page, e-mail, radio and TV)

During the event, hospital will also communicate with employees about:

1. Where and when to report to work

2. How to perform their POD jobs, if applicable

The hospital will also be prepared to provide situational updates for employees, patients and others in the facility at regular intervals for the duration of the event. These updates may be communicated through a variety of ways (notes in elevators, emails, overhead page, meetings, etc.).

After the event, the hospital will communicate the following with employees:

1. Recommended course of medications and the importance of taking all pills until they are finished

2. How to report adverse events

3. The outcome of organization's dispensing effort

4. Questions or concerns employees may have and how to find further information, as needed

B. Communication with Community Partners

Hospital leadership will also communicate with partner organizations during an event to report or obtain critical information. These organizations may include the local public health department, Emergency Operations Center, the Regional Healthcare Coordinator, CRI Coordinator and others. Communication with these entities will be accomplished primarily through phone, e-mail, fax, radio (if applicable) and WebEOC (if applicable).

Contact information for these organizations is as follows:

Local Public Health Department			
Primary Contact:		Secondary Contact:	
Title:		Title:	
Phone:		Phone:	
E-mail:		E-mail:	
Fax:		Fax:	

Emergency Management/Emergency Operations Center			
Primary Contact:		Secondary Contact:	
Title:		Title:	
Phone:		Phone:	
E-mail:		E-mail:	
Fax:		Fax:	

Regional Healthcare Coordinator			
KANSAS		**MISSOURI**	
Primary Contact:	Steve Hoeger	Primary Contact:	Dan Manley
Title:	Hospital Preparedness Program Coordinator	Title:	Hospital Preparedness Program Coordinator
Phone:	816-858-2550	Phone:	816-701-8209
E-mail:	shoeger@kumc.edu	E-mail:	dmanley@marc.org
Secondary Contact:	Ron Marshall	Secondary Contact:	Erin Lynch
Title:	Hospital Emergency Preparedness Program Director, KHERF	Title:	Emergency Services and Homeland Security Program Director, MARC
Phone:	785-224-8152	Phone:	816-701-8390
E-mail:	ronaldwmarshall@gmail.com	E-mail:	elynch@marc.org

(Hospital may wish to include contact information for other organizations here, too.)

C. Media Communications

As with any significant emergency, a Public Information Officer (PIO) will be designated in the HCC upon its activation. This person will serve as the contact with the media during POD operations. The PIO will work with the Incident Commander and other leadership to determine appropriate messages and responses to inquiries. The PIO will maintain the contact information of other key agencies to which the media may be referred that may be better suited to speak to the nature of the event, its impact or other guidance to the public (i.e. local health department).

All employees will receive instruction to refer media inquiries to the hospital PIO and to not respond directly unless instructed to do so by the PIO or Incident Commander.

Hospital security personnel, emergency department personnel and POD Manager will receive instruction on how to handle media that arrive onsite. Media will be asked to move to a designated area away from the POD to minimize impact on its operations.

X. Documentation

Operating a POD will require documentation to maintain health records and manage inventory of SNS assets. The CDC does not encourage stockpiling hard copies of forms in advance of an event as forms may be updated to reflect the latest information at the time of an event. The hospital will have printing capabilities available to produce sufficient copies of forms to operate POD site. **<<Name of Staff Member>>** is responsible for printing all forms and reference materials.

<<Name of Hospital>> will coordinate with the local health department to ensure they have access to the latest forms and handouts related to the event. Documentation will include:

- Individual Medical Screening Forms **(Add the form your facility plans to use here.)** A sample medical screening form is located in Appendix B.

- Format may vary; but contains all information needed to dispense appropriate drug to the individual
- Form may be completed electronically and printed to bring to POD (i.e. Dispense Assist) OR Form will be distributed and hard copy filled in (in advance or at POD)
- Assessment form may be for an individual or collect information for all household members on one form

- Drug Information Sheets
- Agent Fact Sheet (i.e. Anthrax – mode of transmission, symptoms, etc.)
- Adverse Reporting Information

Inventory reports should be maintained throughout POD operations. The POD Manager should review inventory levels frequently to ensure adequate stock and proper documentation is maintained. **(Establish regular time intervals for an inventory review.)** Reports will also be used following the POD operation to identify individuals for whom direct follow-up is needed.

For Missouri hospitals, access the Inventory Tracking spreadsheet through MOHSAIC after you have received your order confirmation. Use this to record data on doses dispensed, remaining, etc.

For Kansas hospitals, inventory tracking is done statewide through Kansas Countermeasure Response Administration (KS-CRA). KS- CRA is an online inventory management and tracking system hosted by KDHE and utilized by the Immunization and Preparedness Programs at state and local levels. KS-CRA has the ability to track medical materiel, (vaccines, pharmaceuticals, personal protective equipment, and other medical supplies), from receipt at the state to distribution to the client. Hospitals and public health departments have logins to this system to record key information. KS-CRA does not have the ability to import information from Excel spreadsheets at this time. It is likely this will require duplicate data entry for hospitals and health departments. **(Note to Kansas Hospitals: Confirm that local health department expects you to submit your POD information in KS-CRA separately or if it will be done at the health department as part of their inventory management plan.)**

****Keep if planning to use Dispense Assist****
Dispense Assist records can be aggregated into an electronic file to maintain records. QR codes printed on each voucher can be scanned and records saved in an Excel Spreadsheet. Instructions on how to retrieve the information from the QR codes can be found at:
https://www.dispenseassist.net/library/QR%20Code%20Data%20Capture%20Walk-Through.pdf

As a back-up to other systems, simple spreadsheets are recommended for tracking purposes. They can be used electronically or paper-based. See sample spreadsheets in Appendix C for capturing information on who received medications and tracking medication supply at the POD.

XI. Demobilization

Ending POD Operations

The Incident Commander will determine when POD operations may be terminated. At that time:

- POD staff will be notified to collect all documentation and turn it in to the POD Manager.
- Unused medical supplies, equipment, and other medical countermeasures will be collected and stored securely. POD Manager will work with Local Public Health department to determine what should be done with remaining SNS assets. All non-SNS materiels can be returned to Materiels Management for redistribution or storage.
- POD staff will also begin to take down POD set-up under the direction of the POD Manager and with input of IT staff. Space will be returned to pre-POD condition.
- A list of supplies used will be created so that items can be replaced as appropriate to maintain operational readiness.
- POD staff will be surveyed on ways to improve POD operations in the future.

<<Name of Hospital>> will follow all chain-of-custody protocols when transferring medical materiel and pharmaceutical assets from one party to another. Guidance on these requirements will be provided by the CDC and state health departments (likely through the Health Alert Network, or HAN).

There may be circumstances that require hospital staff to dispense medication to individuals who were unable to come to the POD while it was open. The HCC should determine if and how this will be handled on a case-by-case basis.

XII. Training and Exercise

A. POD Staff Training

To feel comfortable in assigned roles, personnel should receive training in advance of an actual activation. This training should include the following:

1. Review of this POD PLAN
2. Review of relevant components of EOP (i.e. Command Structure)
3. ICS training (include any forms that may be used in POD)
4. Orientation to POD Logistics and Layout
5. Training on technology to be used. This could include dispensing site tools like Dispense Assist or communications mechanisms such as WebEOC. It may also include ordering/inventory tracking systems (KS-CRA or MOHSAIC). If personnel will be expected to use programs in their various roles, training should be provided (annually at minimum) to ensure comfort level with using these tools.

B. Exercises

In addition, exercises are needed to go through the process of activating, setting up and operating the POD. Following any activation of the POD (including exercises or real-world events such as flu clinics) there will be consideration given to improvement planning. Areas for improvement will be documented with recommendations for corrective action. Many times, these recommendations will require additional training or revisions to the procedures outlined in this plan.

XIII. Plan Updates and Maintenance

The Hospital Emergency Planner shall be responsible for updating and maintaining the POD Plan. It will be reviewed and updated on an annual basis (most likely following relevant exercises).

The Plan will be re-submitted to the Local Public Health Department each time it is revised significantly to ensure the Plan aligns with the broader community approach and remains accurate in terms of hospital and public health roles and responsibilities. The health department may review the Plan and make recommendations to the hospital as appropriate.

XIV. References

- Public Health Preparedness Capabilities: National Standards for State and Local Planning, March 2011; U.S. Department of Health and Human Services, Centers for Disease Control and Prevention
- Kansas Department of Health and Environment Standard Operating Guides: Mass Dispensing SOG; http://www.kdheks.gov/cphp/operating_guides.htm, accessed June 2013
- Missouri Department of Health and Senior Services. A POD Managers Workbook, Sep 2005, https://health.mo.gov/BT_Response/FinalPODWorkbookSep05.pdf
- Bio-Defense Network Workbook, Chapter 4 – Closed POD Plan Guidance; http://www.pandemicprep.org/bio-defense-program/bio-defense-network-workbook/, accessed July 2013.
- Bioterrorism and Other Public Health Emergencies, Community-Based Mass Prophylaxis; A Planning Guide for Public Health Preparedness; AHRQ Pub No. 04-0044, Aug 2004
- Washington State Regional IV Public Health, Mass Prophylaxis, Point of Dispensing (POD), Field Operations Guide (FOG), May 2009
- Beyond Getting Started, A Resource Guide: Preparing for Mass Immunization/Prophylaxis of Healthcare Personnel, Second Edition, Summer 2012, Association of Occupational Health Professionals

XV. Appendices

A. POD Layout

B. Medical Screening Form

C. Inventory Management

D. Useful Resource Information

Appendix A. Pod Layout

Diagram of POD Layout

Use this space to mock up the layout of the POD site.

Appendix B. Medical Screening Form

The hospital can expect to receive a medical screening form to use from the local health department. As a sample, this is the paper form from Dispense Assist

(https://www.dispenseassist.net/library/Paper%20Form%20-%20Antibiotic.pdf).

Step 1 LIST ALL HOUSEHOLD MEMBERS FOR WHOM YOU ARE PICKING UP MEDICATIONS TODAY, INCLUDING YOURSELF		**Step 2** FOR EACH HOUSEHOLD MEMBER LISTED BELOW, ANSWER ALL QUESTIONS.				FOR PUBLIC HEALTH WORKER'S USE ONLY **Drug Assignment**	
		Question 1 • Is this person allergic to doxycycline or other "cycline" drugs? • Is this person pregnant?	**Question 2** • Does this person have difficulty swallowing pills? • Is this person both less than 90 pounds and less than 18 years of age?	**Question 3** • Is this person allergic to Ciprofloxacin or "floxacin" drugs? • Does this person have seizure disorder or epilepsy? • Is this person taking Tizanidine (Zanaflex)?	**Question 4** • Does this person have difficulty swallowing pills? • Is this person both less than 90 pounds and less than 18 years of age?		
Last name	**First name**	If yes to any, write yes If no to all, write no	If yes to any, write yes If no to all, write no	If yes to any, write yes If no to all, write no	If yes to any, write yes If no to all, write no		
							Lot #
							Lot #
							Lot #
							Lot #
							Lot #
							Lot #
							Lot #
							Lot #
Step 3 Write in your address and telephone number to the right. If more than one, include all.		Address:		Telephone:			
Instructions for Public Health Worker *(follow the instructions to the right for each individual)*		*Q1:* • *If no, evaluate question 2.* • *If yes, skip to Question 3*	*Q2* • *If no, provide doxycycline and stop.* • *If yes, provide doxycycline and emergency preparation instructions and stop.*	*Q3* • *If no, evaluate question 4.* • *If yes, advise person to seek medical consult*	*Q4* • *If no, provide ciprofloxacin.* • *If yes, advise person to seek medical consult*		

Appendix C. Inventory Management

Sample Master Tracking Form

RX #	Last Name	First Name	DOB	Medication	Dose	Quantity	Lot	Exp Date
5432	Smith	Samuel	5/18/1975	Cipro	500mg	30	U452aa	5/30/2015
5433	Smith	Amanda	12/5/1977	Cipro	500mg	30	U452aa	5/30/2015

Sample Medication Inventory Management Form

(Back-up form to state-provided forms in KS-CRA and MOHSAIC)

Drug	Dose	Packaged Quantity	Initial Doses Received	Doses Dispensed at end of OP #1*	***Additional*** doses Dispensed at end of OP #2	***Additional*** doses Dispensed at end of OP #3	Remaining Doses on hand
SAMPLE DRUG	*100mg*	20 tabs per bottle	*1000*	*150*	*200*	*485*	*165*
Doxycycline	100mg	20 tabs per bottle					*0*
Doxycycline, oral suspension	25mg/5mL	60mL bottle, powder					*0*
Ciprofloxacin	500mg	20 tabs per bottle					*0*
Cipro, oral suspension	250mg/mL	100mL bottle, powder					*0*
Other							*0*
		Totals:					
* OP = Operational Period (likely 12-hour shifts)							

Appendix D. Other Useful Resources

These websites and online materials may be useful in finalizing the plan, or during an event.

RESOURCE	LOCATION	DESCRIPTION
CDC Emergency Preparedness & Response	http://www.bt.cdc.gov/	Access latest fact sheets on agents; updated information during an event
KDHE Preparedness	http://www.kdheks.gov/cphp/index.htm	State-specific information; links to other useful websites.
MO DHSS SNS website	http://health.mo.gov/emergencies/sns/index.php	MO-specific information. Details on training opportunities; links to other websites.
Kansas City MSA Cities Readiness Initiative (CRI) Region Website	http://www.kscri.org	Information on planning efforts in KS CRI region.
Kansas City - Cities Readiness Initiative (CRI) - MARC	http://www.marc.org/cri/	Just-in-time training videos; not Closed POD specific, but provides introduction to POD operations
KS-Train	https://ks-train.org	KS-specific training

System Access Information

Use this table to store system information for easy access. Remember that personal access information should not be stored electronically.

SYSTEM	URL	LOGON NAME	PASSWORD
EMSystem	https://emresource.emsystem.com/login.jsp		
WebEOC	Varies by jurisdiction		
MOHSAIC			
KS-CRA	http://www.kdheks.gov/it_systems/ks-cra.htm		
Dispense Assist	https://www.dispenseassist.net/		

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ESF 8 ATTACHMENT M

ATTACHMENT M:

MEMS Guide

ATTACHMENT M. MEMS GUIDE

I. Executive Summary

MODULAR EMERGENCY MEDICAL SYSTEM (MEMS)

The MEMS Guide developed for the Region is designed to address the gap in resources existing if a large number of patients were to seek treatment from local healthcare systems. The MEMS provides a scalable and flexible organizational model to assist jurisdictions in increasing local and regional surge capacity and successfully managing the consequences of a major emergency event.

Success of the MEMS depends greatly on the appropriate expansion of the existing local healthcare infrastructure to meet the needs of a large-scale event. With this in mind, the MEMS implemented in the bi-state region will follow this model by enhancing existing systems and expanding on the healthcare systems and emergency plans and guidelines already in place (e.g., the MARCER Mass Casualty Incident Plan [MCI] Plan, hospital plans, local public health agency plans, local Emergency Operations Plans [EOPs], etc.).

There are several components of the MEMS that may be implemented when and as necessary, based on the event and the needs of the jurisdictions involved, such as a Neighborhood Emergency Help Center (NEHC), Medical Command Center (MCC), Casualty Transportation System (CTS), Alternate Care Site (ACS), as well as Community Outreach and Mass Fatalities functions.

- **Appendix 1**: Neighborhood Emergency Help Center Guidelines
- **Appendix 2**: Special Needs Shelters (SpNS) Guidelines
- **Appendix 3**: Medical Command Center (MCC)/ District Healthcare Coordination Center (DHCC) Guidelines
- **Appendix 4**: Casualty Transportation System (CTS) Guidelines
- **Appendix 5**: Alternate Care Site (ACS) Guidelines
- **Appendix 6**: Community Outreach – Public Information Guidelines
- **Appendix 7**: Mass Fatality Guidelines (Maintained as a separate document – see MARC for sample)
- **Appendix 8**: Northern and Southern Districts Communications Directory (see revised/updated directory maintained by MARC)

II. Scope & Applicability

The MEMS Guide is an Attachment to Emergency Support Function (ESF #8) of the Regional Coordination Guide (RCG) and has been developed for all of the jurisdictions in the nine (9) county, bi-state metropolitan region.

III. Accessing the Plan

To access the MEMS Guide, please contact the Mid-America Regional Council.

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ESF 8 ATTACHMENT N

ATTACHMENT N:

WEBEOC

ATTACHMENT N. WEBEOC

The Region is currently enhancing WebEOC capabilities. Subsequent updates will include WebEOC protocols and procedures.

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ESF 8 ATTACHMENT O

ATTACHMENT O:

Healthcare Related MOUs

ATTACHMENT O. HEALTHCARE RELATED MOU

MISSOURI HOSPITAL MUTUAL AID AGREEMENT

Description: The purpose of this Statewide Hospital Mutual Aid Agreement (MAA) is to establish a coordinated system through which hospitals throughout Missouri and in adjoining states will provide mutual aid to each other as necessary in order to support emergency medical care needs in a medical disaster.

To Access this Document, Contact:

- Mid-America Regional Council
- Maintained on EMResource

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ESF 8 ATTACHMENT P

ATTACHMENT P:

Technologies and Systems Overview

ATTACHMENT P. TECHNOLOGY AND SYSTEMS OVERVIEW

BIOSENSE

The BioSense program is a public health surveillance system that increases the ability of health officials at local, state, and national levels to efficiently, rapidly and collaboratively monitor and respond to harmful health effects of exposure to disease or hazardous conditions. BioSense provides public health officials a common electronic health information system with standardized tools and procedures for rapidly collecting, sharing, and evaluating information.

Mandated in the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, the CDC BioSense Program was launched in 2003 to establish an integrated national public health surveillance system for early detection and rapid assessment of potential bioterrorism-related illness.

- Kansas is utilizing BioSense 2.0 to conduct syndromic surveillance. At this time, KDHE is only working with eligible hospitals only. KDHE is also working with the Health Information Exchanges (HIE) in Kansas to provide hospitals with an option of connecting to BioSense through the HIE.

- Missouri border hospitals report data to BioSense through Missouri ESSENCE. Six Kansas facilities in the Kansas City Metro area are reporting in this manner.

CHEMICAL EVENT SHIPPING SUPPLY LOCATIONS (CESSL) PROGRAM

In the State of Kansas, the CESSL program allows for prepositioning of category B shipping containers and packaging materials which will enable the Health Professionals closest to a chemical event to collect specimens from persons within the exposure area. KDHE and KHEL have created cache sites based on distance distribution and population density at many hospitals throughout Kansas. KDHE maintains a list of these sites. More information is available from local health departments or KDHE.

DISPENSE ASSIST

Per a directive from the Centers for Disease Control and Prevention large metropolitan regions have been tasked with delivering medication to the public within 48 hours after notification of a biological emergency event. Dispense Assist supports public health agencies with accomplishing this mission by providing an online screening tool that allows users to generate vouchers for medication. Dispense Assist is a mass dispensing tool developed and maintained by the Johnson County Dept. of Health and Environment as a sustainable system. It is utilized by jurisdictions across the country and territories. Use of the system is free and available 24/7 via the internet www.dispenseassist.com as well as Apple iTunes and Google Play Store.

EMRESOURCE

EMResource is a Web-based program providing real-time information on hospital emergency department status, hospital patient capacity, availability of staffed beds and available specialized treatment capabilities. The system links all acute care hospitals and many EMS agencies in Region A. It is the region's primary method of communicating hospital status and capabilities and coordinating patient routing. EMResource utilizes Emergency Medical Coordinating Centers (EMCCs) throughout the region to coordinate information, and the states may also use the system to conduct bed polling in statewide events. For more detailed information on the EMResource and its use, see the EMResource Protocols and Policies Manual.

FIRST WATCH

Is a Web-based software product for syndromic surveillance, early event detection, situational awareness, and operational reporting by Stout Solutions, LLC. In the Kansas City metropolitan area, monitored services provide ambulance dispatch information to FirstWatch, which analyzes the data for patterns and spikes in specific types of calls.

The region utilizes FirstWatch to monitor the call volume of the four largest EMS agencies in the Kansas City metropolitan region. FirstWatch monitors data 24/7 from the respective computer aided dispatch systems and compares it to the historical average for that time period. FirstWatch monitors four parameters, the call volume, the transport volume, the patient offload time, and the overall mission time. When an individual agency reaches an alert level for their particular agency, FirstWatch delivers alerts through selected media (pager, SMS message, email) to that agency's designated users. When the region reaches an alert level for the four agencies combined, FirstWatch delivers alerts through selected media (pager, SMS message, email) to designated regional users. This includes individual EMS agencies, hospitals, emergency management, and public health departments throughout the region.

HEALTH ALERT NETWORKS (HAN)

Notification of a biological event may come through one of the two Health Alert Networks (HANs) serving the area. The Kansas City, Missouri Health Department (by contract with DHSS) serves as the regional HAN hub for the Missouri side of the metropolitan area and the Kansas Department of Health and the Environment (KDHE) HAN serves the Kansas side.

- KS-HAN is a secure, web-based electronic communication system that enables local and state health and safety entities to share public and environmental health information rapidly. The system allows users to send, receive and discuss information of public and environmental health importance in a secure environment. It also allows for the rapid notification of any and all users in the event of an emergency, when the timely distribution of recommendations on investigation, prevention and treatment is critical.
    - KS-HAN contains over 3,000 participants from local health departments, hospitals, emergency medical services, animal health, clinics, state agencies, private and public health laboratories and other first responders across the state.
    - KS-HAN is supported by federal funding from the National Bioterrorism Hospital Preparedness Program (NBHPP).
    - If you wish to participate in KS-HAN please email your name, employer, employer phone number, job title or description to mailto: kshanadmin@kdheks.gov

- MO-HNS: The Missouri Health Notification System (MO-HNS) is a secure web-based system accessible anytime and anywhere for emergency planning and response communication with public health partners. The Missouri Department of Health and Senior Services administers MO-HNS to facilitate alerting and collaboration between federal, state, local Public Health Departments, clinics, hospitals, and other public health emergency partners on a 24/7/365 basis.
    - What are the Categories of Health Alert messages?
        - Health Alert: conveys the highest level of importance; warrants immediate action or attention.
        - Health Advisory: provides important information for a specific incident or situation; may not require immediate action.

- Health Update: provides updated information regarding an incident or situation; unlikely to require immediate action.
- Health Information: provides general health information that is not considered to be of an emergent nature.

HOSPITAL EMERGENCY AND ADMINISTRATIVE RADIO SYSTEM (HEAR)

The Hospital Emergency Administrative Radio (HEAR) system links all acute care hospitals on a single channel radio system (155.340 MHz). The HEAR system serves as a backup to the EMResource system in the event of a Mass Casualty Incident (MCI) or other major health and medical emergency. The HEAR system is operated from a primary control hospital in the region and when a HEAR alert has been issued; the primary control hospital will contact the other hospitals in the region and collect bed and patient treatment capability information.

MISSOURI ESSENCE

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) software is a system that inputs electronic emergency department (ED) data for the purpose of syndromic surveillance. Syndromic surveillance is the use of non-traditional data sources in order to detect public health events earlier than possible with other methods (laboratory confirmed diagnosis, physician diagnosis). Examples of syndromic surveillance data include over-the-counter drug sales, laboratory report orders, and absenteeism rates.

Missouri conducts syndromic surveillance using electronic hospital emergency department (ED) visits. DHSS receives data from hospitals meeting certain criteria under 19 CSR 10-33.040 specifically for syndromic surveillance.

ESSENCE groups chief complaints from electronic ED data into 'syndrome' categories. This information is used to determine if the number of visits is greater than expected for that facility based on historical data and statistical analyses to conduct early event detection. Syndrome groups used are: botulism-like, fever, gastrointestinal, hemorrhagic illness, neurological, rash, respiratory, and shock/coma.

ESSENCE can also be used for situational awareness during known health events by querying all ED visits for a particular syndrome or by keyword (such as carbon monoxide, animal bite, injury, etc.).

MISSOURI HEALTH STRATEGIC ARCHITECTURE AND INFORMATION COOPERATIVE (MOHSAIC)

MOHSAIC ties separate pools of information together in a centralized database, and creates a robust client/server network giving public health care workers easy access to historical and administrative information. The system gives health care practitioners holistic information, allowing them to analyze any aspect of health care and be proactive in dealing with public health threats.

MISSOURI TELEHEALTH NETWORK (MORENET)

The Missouri Telehealth Network (MORENET) connects rural hospitals, mental health clinics, Federally Qualified Health Centers (FQHC) and other medical service providers via an interactive videoconferencing/conferencing network that will support the delivery of disaster preparedness communications and educational programming. The system provides a mechanism to remotely provide clinical services during disasters and is used to link hospitals, Centers for Disease Control and Prevention (CDC) and other entities in other states.

THE KANSAS COUNTERMEASURE RESPONSE ADMINISTRATION (KS-CRA)

The Kansas Countermeasure Response Administration (KS-CRA) is an online inventory management and tracking system hosted by Preparedness, but utilized by the Immunization and Preparedness Programs at

state and local levels. KS-CRA has the ability to track vaccines, medications, and Personal Protective Equipment from receipt at the state to distribution to the patient. This allows federal, state, and local governments to accurately and easily track inventory and distribution.

WEBEOC

WebEOC allows jurisdictions to communicate information regarding emergency events in real time via the Internet. In addition to local WebEOC capabilities, regional WebEOC Boards have been developed to assist jurisdictions in the region in maintaining regional communications and coordination.

X-SENTINEL

X-Sentinel™ is an inter-jurisdictional surveillance system to support disease and event case management across borders. X-Sentinel allows users to search across the two state's disease surveillance systems and immediately obtain de-identified data and new case reports. Regional case data is available for viewing and analysis, and users may set user-specific case alert rules.

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ESF 8 ATTACHMENT Q

ATTACHMENT Q:

Protocol for Regional News Releases

ATTACHMENT Q. PROTOCOL FOR REGIONAL NEWS RELEASES

Routine Releases: Routine releases are releases that result from day-to-day routine activities. They cover messages of a relatively promotional nature that the Local Public Health Agencies (LPHAs) want to get out to the media and the public. They could address celebrations or national health holidays (National Public Health Week, Take a Loved One to the Doctor Day, etc.) As there is usually plenty of notification of when these events will occur, LPHA's should begin the collaboration process, at a minimum, two weeks before the intended release date. This protocol does not preclude individual agencies from issuing their own releases; if and when a stand-alone release is issued by any department, a courtesy cc or bcc to other health departments in the region is appreciated.

Urgent Releases: Urgent releases are releases that have relevance about an ongoing or pending event where LPHA's are encouraging people to take some action. It is vital for the media and the public to keep these things in mind and remember them in the next few days or months as a situation occurs. This could address unfavorable weather conditions (heat waves or extreme cold) or threatening communicable disease threats (i.e. pertussis outbreak, flu). Ideally, there will be some warning that the event is coming. These should be released no less than 24 hours prior to the event taking place, or as soon as possible after knowledge of an event or situation is suspected or confirmed.

Emergency Release: Emergency Releases are releases of such an emergent nature that the message needs to get out immediately as lives could be at risk. This could cover a number of events of a naturally-occurring or intentional nature (boil order, shelter in place, SNS, BT event, etc.). As this information is critical to reducing morbidity and mortality, time is of the essence. As short turnaround time is essential. Work should commence immediately and be completed within 60-90 minutes.

Activation: Any LPHA may suggest a regional presser. While the task force does not anticipate any concerns about the routine releases, or for that matter, the urgent releases, the challenges are the emergency releases. It will take time for all PIOs to be notified, a draft get distributed, approval from the directors/administrators, and feedback ("go" or "amend") to happen.

1. The initiating LPHA will notify all other LPHA directors and PIOs of the situation
    a. Primary – Email
    b. Secondary – Phone (Depending on the situation, the phone may be immediately incorporated into the notification process.)
2. The initiating LPHA will be the coordinator for gathering all information and creating the draft.
3. The draft will be sent out for comment from all PIOs and Directors/ Administrators. A time-limit will be set for comments to be submitted.
4. A "go" or "amend" will then occur. Directors/Administrators and PIOs may either approve the release, opt out or request changes. If there is no consensus or quorum, the PIO will amend until consensus is reached.
5. Following approval by a consensus or quorum of Directors/Administrators, the original LPHA will work with the Mid America Regional Council Public Relations Office to distribute the release to the MARC region media (BHensley@marc.org).

(Note – While the intent is to achieve consensus from all participating LPHAs, there may be occasions when this will not be possible. When a news release must go out in a short time, and the approval of all LPHAs cannot be achieved due to technical or other unforeseen circumstances, the release will be issued when at least five of the participating LPHA's with a combined coverage of at least 67% of the population agree to issue it.)

MARC LPHD Population Census

	Population	%
Cass County	99,281	5.3
Clay County	108,524	5.8
Independence	116,830	6.2
Jackson County	254,829	13.5
Johnson County	544,179	28.8
Kansas City	459,787	24.4
Leavenworth County	76,227	4.0
Platte County	45,646	2.4
Ray County	23,494	1.2
Unified Government	157,505	8.3
Total	1,886,302	100.0%

(Updated 9/27/11)