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

<table>
<thead>
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<th>CHANGE NUMBER</th>
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<th>CHANGE/COMPLETED BY</th>
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<tr>
<td>1</td>
<td>July - December 2005</td>
<td>Major Plan Revision MARCER Planning Subcommittee</td>
<td>January 2006</td>
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<td>2</td>
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<td>Minor Plan Updates Planning Subcommittee/MARC staff</td>
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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 Policies 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.

<table>
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<tr>
<td>Kansas City, MO Fire Department Communications</td>
<td>816-923-3456</td>
</tr>
<tr>
<td>Lee’s Summit Fire Department Communications</td>
<td>816-969-7407</td>
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</table>
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/confine ment 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.

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<td>Primary Control Hospital</td>
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<tr>
<td>Alternate Control Hospital</td>
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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

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<th>AGENCY</th>
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<td>Lawrence Douglas County Fire and Medical</td>
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<td>Prairie Township Fire Protection District</td>
<td>816-525-4200</td>
<td>1</td>
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<tr>
<td>Raytown EMS</td>
<td>816-737-6030</td>
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<td>Sni Valley Fire Protection District</td>
<td>816-969-7407</td>
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<td>AGENCY</td>
<td>24 HR. PHONE</td>
<td>NUMBER OF AMBULANCES</td>
<td>AVERAGE NUMBER IN SERVICE 24 HOURS A DAY</td>
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<td>JOHNSON COUNTY, KS</td>
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<td>Johnson County Fire District #2</td>
<td>913-432-2121</td>
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<td>Lenexa Fire Department</td>
<td>913-432-2121</td>
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<tr>
<td>Johnson County Med Act (serves all cities located in Johnson County)</td>
<td>913-432-2121</td>
<td>16</td>
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<td>LEAVENWORTH COUNTY</td>
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<tr>
<td>Leavenworth County EMS</td>
<td>913-682-5724</td>
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<td>RAY COUNTY</td>
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<tr>
<td>Ray County EMS</td>
<td>816-470-3030</td>
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<tr>
<td>WYANDOTTE COUNTY</td>
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<tr>
<td>American Medical Response – Wyandotte/Johnson Counties</td>
<td>816-461-3699</td>
<td>3</td>
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<td>Bonner Springs EMS</td>
<td>913-596-3050</td>
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<td></td>
<td>913-422-7744</td>
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<td>KCK Fire/EMS</td>
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<td>9</td>
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<tr>
<td>Edwardsville, KS EMS</td>
<td>913-422-5460</td>
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<td>MIAMI COUNTY</td>
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<tr>
<td>Miami County EMS</td>
<td>913-827-2602</td>
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<table>
<thead>
<tr>
<th>AIR EMS PROVIDERS IN METRO KANSAS CITY</th>
<th>24 HR. PHONE</th>
<th>NUMBER OF HELICOPTERS</th>
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<tr>
<td>Life Net of the Heartland – St. Joseph</td>
<td>1-800-981-3062</td>
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<tr>
<td>Life Flight Eagle</td>
<td>1-800-422-4030</td>
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<tr>
<td>Life Star Air Ambulance - Lawrence</td>
<td>1-800-666-9111</td>
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<table>
<thead>
<tr>
<th>GROUND &amp; AIR EMS PROVIDERS OUTSIDE METRO KANSAS CITY</th>
<th>AVERAGE RESPONSE TIME TO METRO AREA</th>
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<tbody>
<tr>
<td>GROUND AGENCY</td>
<td>24 HR. PHONE</td>
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<tr>
<td>Topeka – AMR</td>
<td>785-232-2222</td>
</tr>
<tr>
<td>Wichita – Emergency Communications Admin</td>
<td>316-383-7077</td>
</tr>
<tr>
<td>Columbia – Joint Communications</td>
<td>573-442-6131</td>
</tr>
<tr>
<td>Springfield – Mercy EMS</td>
<td>417-820-3003</td>
</tr>
<tr>
<td>Springfield – Cox Ambulance Service</td>
<td>417-269-3000</td>
</tr>
<tr>
<td>St. Joseph – Buchannan County EMS</td>
<td>816-271-6558</td>
</tr>
<tr>
<td>Sedalia – (PCAD) Pettis County Ambulance Dist.</td>
<td>660-829-0777</td>
</tr>
<tr>
<td>AIR AGENCY</td>
<td>Activate through local EOC</td>
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<tr>
<td>------------</td>
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</tr>
<tr>
<td>KS / MO National Guard and Reserves (may not be available due to world events)</td>
<td>800-247-3822</td>
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<tr>
<td>Sedalia – Air Evac</td>
<td>800-433-5433</td>
</tr>
<tr>
<td>Springfield – Mercy Life Line Air Med (Bolivar)</td>
<td>800-333-5269</td>
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<tr>
<td>Springfield – Cox Air Care</td>
<td>800-325-5400</td>
</tr>
<tr>
<td>Columbia – Staff of Life (LaMonte Base)</td>
<td>800-348-1281</td>
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**REGIONAL HOSPITALS**

<table>
<thead>
<tr>
<th>REGIONAL HOSPITALS</th>
<th>ADDRESS</th>
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<tr>
<td><strong>MISSOURI</strong></td>
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</tr>
<tr>
<td>Belton Regional Medical Center***</td>
<td>17065 So. 71 Hwy. Belton, MO 64012</td>
<td>816/348-1281</td>
</tr>
<tr>
<td>Cass Medical Center***</td>
<td>1800 East Mechanic Harrisonville, MO 64701</td>
<td>816/380-5888</td>
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<tr>
<td>Centerpoint Medical Center**</td>
<td>19600 E. 39th St. Independence, MO 64057</td>
<td>816/698-7000</td>
</tr>
<tr>
<td>Children’s Mercy Hospital*</td>
<td>2401 Gillham Road Kansas City, MO 64108</td>
<td>816/234-3826</td>
</tr>
<tr>
<td>Excelsior Springs Medical Center</td>
<td>1700 Rainbow Blvd. Excelsior Springs, MO 64024</td>
<td>816/630-6081</td>
</tr>
<tr>
<td>Lee’s Summit Medical Center***</td>
<td>2100 SE Blue Parkway Lee’s Summit, MO 64081</td>
<td>816/282-5000</td>
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<tr>
<td>Liberty Hospital**</td>
<td>2525 Glen Hendren Drive Liberty, MO 64069</td>
<td>816/781-7200</td>
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<tr>
<td>North Kansas City Hospital**</td>
<td>2800 Clay Edwards Drive NKC, MO</td>
<td>816/691-2057</td>
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<tr>
<td>Research Brookside Campus</td>
<td>6601 Rockhill Rd. Kansas City, MO 64131</td>
<td>816/276-4546</td>
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<tr>
<td>Research Medical Center*</td>
<td>2316 E. Meyer Blvd. Kansas City, MO 64132</td>
<td>816/276-4155</td>
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<tr>
<td>St. Luke’s Hospital Kansas City*</td>
<td>4401 Wornall Road Kansas City, MO 64171</td>
<td>816/932-6233</td>
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<tr>
<td>St. Luke’s Northland Barry Rd.</td>
<td>5830 Barry Road Kansas City, MO 64154</td>
<td>816/891-6000</td>
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<tr>
<td>St. Luke’s Northland Smithville</td>
<td>601 So. 169 Hwy Kansas City, MO 64089</td>
<td>816/532-3700</td>
</tr>
<tr>
<td>St. Joseph Medical Center</td>
<td>1000 Carondelet Drive Kansas City, MO 64114</td>
<td>816/942-4400</td>
</tr>
<tr>
<td>St. Mary’s Medical Center</td>
<td>201 NW R.D. Mize Road Blue Springs, MO 64014</td>
<td>816/228-5900</td>
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<tr>
<td>Truman Medical Center*</td>
<td>2301 Holmes Kansas City, MO 64108</td>
<td>816/404-2661</td>
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<tr>
<td>Truman Lakewood Medical Center</td>
<td>7900 Lee’s Summit Road Lee’s Summit, MO</td>
<td>816/404-7000</td>
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<tr>
<td><strong>KANSAS</strong></td>
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<tr>
<td>Children’s Mercy Hospital South</td>
<td>5808 W. 110th St. Overland Park, KS 66211</td>
<td>913/696-8000</td>
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<tr>
<td>Cushing’s Memorial Hospital</td>
<td>711 Marshall Leavenworth, KS 66408</td>
<td>913/684-1389</td>
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<tr>
<td>Lawrence Memorial Hospital</td>
<td>325 Maine St Lawrence, KS 66044</td>
<td>913/505-6237</td>
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<tr>
<td>Hospital Name</td>
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<td>Phone</td>
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<tr>
<td>-----------------------------------</td>
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<tr>
<td>Miami County Medical Center</td>
<td>2100 Baptiste Dr. Paola, KS 66071</td>
<td>913/294-6655</td>
</tr>
<tr>
<td>Menorah Medical Center</td>
<td>5721 W. 119th Street Overland Park, KS 66209</td>
<td>913/498-7707</td>
</tr>
<tr>
<td>Overland Park Regional**</td>
<td>10500 Quivira Road Overland Park, KS 66215</td>
<td>913/541-5946</td>
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<tr>
<td>Providence Medical Center</td>
<td>8929 Parallel Kansas City, KS 66112</td>
<td>913-596-4000</td>
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<tr>
<td>Olathe Medical Center</td>
<td>20333 W. 151st Street Olathe, KS 66061</td>
<td>913/791-4200</td>
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<tr>
<td>Saint Luke’s South Hospital</td>
<td>12300 Metcalf Ave. Overland Park, KS 66213</td>
<td>913/317-3477</td>
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<tr>
<td>Saint John Hospital</td>
<td>3500 So. Fourth St. Leavenworth, KS 66408</td>
<td>913/680-6000</td>
</tr>
<tr>
<td>Shawnee Mission Medical Center</td>
<td>9100 W. 74th St. Shawnee Mission, KS 64204</td>
<td>913/676-2208</td>
</tr>
<tr>
<td>University Of Kansas Hospital*</td>
<td>3901 Rainbow Blvd. Kansas City, KS 66160</td>
<td>913/588-0393</td>
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**KANSAS**

**NON-REGIONAL HOSPITALS**

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Address</th>
<th>Phone</th>
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<tbody>
<tr>
<td>Atchison Hospital</td>
<td>Atchison County</td>
<td>(913) 367-6624</td>
</tr>
<tr>
<td>Mosaic Life Care **</td>
<td>St. Joseph</td>
<td>(816) 271-6000 (ER) 816-271-6122</td>
</tr>
<tr>
<td>Lafayette Regional Health Center</td>
<td>Lafayette and Ray Counties</td>
<td>(660) 259-6862</td>
</tr>
<tr>
<td>Western Missouri Medical Center</td>
<td>Warrensburg</td>
<td>(660) 747-8824</td>
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</table>

* 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.
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.