2022

BI-STATE

KANSAS CITY REGION

Regional Mass Casualty Incident Plan

MASS CASUALTY INCIDENT PLAN

MARCER MCI PLAN

MID-AMERICA REGIONAL COUNCIL
EMERGENCY RESCUE COMMITTEE (MARCER)

REGIONAL MASS CASUALTY INCIDENT PLAN FOR METROPOLITAN KANSAS CITY

July 2022

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
6	June 2019	Plan Update	June 2019
7	February-July 2022	Plan Update	August 2022

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. As the number and diversity of potential MCIs increase, especially those considered Hostile Events, it is imperative EMS agencies responding to these incidents have common priorities. It is also imperative that other response disciplines are aware of the scope of capability of their response partners. This plan is intended to serve as a regional template for local plans with the goal of standardizing priorities, language and terminology within and across disciplines.

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 kcrhcc@gmail.com.

Chip Portz, Chief of Community Risk Reduction
Central Jackson County Fire Protection District
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 an MCI incident and provide an official plan for use by EMS agencies throughout the region.

Metropolitan Kansas City is fortunate to be served by a sizable number of EMS agencies and hospitals. There are over 56 state-licensed EMS agencies, including EMS departments, fire departments, air ambulance services and other providers. The nine-county, bi-state region is served by 29 major hospitals. A list of these resources is available in EMResource.

E. 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 pre-hospital 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 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, and Miami counties in Kansas. All EMS agencies and hospitals serving all or portions of these nine (9) counties or located within these counties are covered by this plan, unless indicated otherwise.

Regional Coordination

A. The Kansas City Metropolitan Healthcare Council provides opportunities for information sharing and cooperation through maintenance of EMResource, in coordination with Missouri Hospital Association; and coordinates with MARCER the annual review and updates of the *Greater Kansas City Metropolitan Area Community Plan for Diversion.*

B. The MARC Region Health Care Coalition (HCC) meets regularly and coordinates with leadership representing Hospitals, EMS, Public Health, Emergency Management and others to discuss preparedness and response to all hazards, including MCI events. In addition, HCC staff and stakeholders serve as Kansas City Duty Officers to maintain situational awareness of regional events on a continual basis.

C. The Regional Homeland Security Coordinating Committee (RHSCC) Hospital Committee 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 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 Kansas City Trauma Program Managers meet regularly to share information, coordinate training and provide important input to regional emergency medical issues.

E. The MCI Plan is coordinated with several other regional plans, such as the EMResource Protocols and Polices Manual and the *Greater Kansas Metropolitan Area 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.**

F. While Mass Casualty Incidents may take many forms, additional, specific MCI training for incidents during which active intentional violence is involved is ongoing in the form of Kansas City Regional Hostile Events Integrated Response Training (HEIRT).

Definitions

A. Complex Coordinated Terrorist Attack (CCTA) acts of terrorism that involve synchronized and independent team(s) at multiple locations. Involving well trained team(s) at multiple locations, sequentially or in close succession, initiated with little or no warning, and employing one or more weapon systems: firearms, explosives, fire as a weapon, and other nontraditional attack methodologies that are intended to result in large numbers of casualties and fatalities.

B. Hostile Events Integrated Response Training (HEIRT) – an eight-hour course for regional Law Enforcement and Fire/EMS. Focus is on the time period after the threat has ended and efforts to stop the dying begins. Casualty Collection Points and evacuation are part of the course. HEIRT definitions and terminology can be found in **Appendix G**.

C. Kansas City Hostile Event Integrated Response Framework - The Kansas City Hostile Event Integrated Response Framework outlines common practices and terminology for responding to intentional attacks. It is intended to provide guidance to help ensure that the myriad agencies likely to respond to the incident are working from the same assumptions and using collectively agreed upon terminology and techniques. This will allow for a better integrated response in order to expedite patient treatment and transport. This framework is meant to supplement, but never supersede, local plans and authorities; it is for the internal use of participating emergency services departments within the Kansas City metro region.

D. Mass Casualty Incident For purposes of this plan, a mass casualty incident, or MCI, is any 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

MCI Levels
Level V: 5-9 patients *Locally managed event* 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: 10-24 patients *Typically locally managed event* 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: 25-49 patients *Regional coordination expected* 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 talk group on the regional radio system.
Level II: 50-99 patients *Regional/state coordination necessary* 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 talk group on the regional radio system.
Level I –100+ *Significant inter-agency coordination necessary* 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 talk group 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 inter-agency coordination and ensure 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 using mutual aid resources.

D. 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

Initial Incident Priorities

1. Assess the scene and check for unusual hazards and/or threats (e.g., hazardous materials, hostile event, etc.)

2. During all MCI incidents, and especially during incidents involving a hostile event, responder safety should be the initial priority. Withdrawing from the scene or staging until the arrival of Law Enforcement should be considered. The actions of Fire/EMS crews while awaiting security of the scene and asset formation with Law Enforcement should be guided by local jurisdiction operational guidelines and policies.

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

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

5. Mutual Aid needs are requested based on the local agency's procedures.

6. Establish command/unified command and announce the location.

7. Dependent on size/scope/type of incident, Identification area of safe refuge.

8. Assign or initiate triage.

9. Establish patient tracking early.

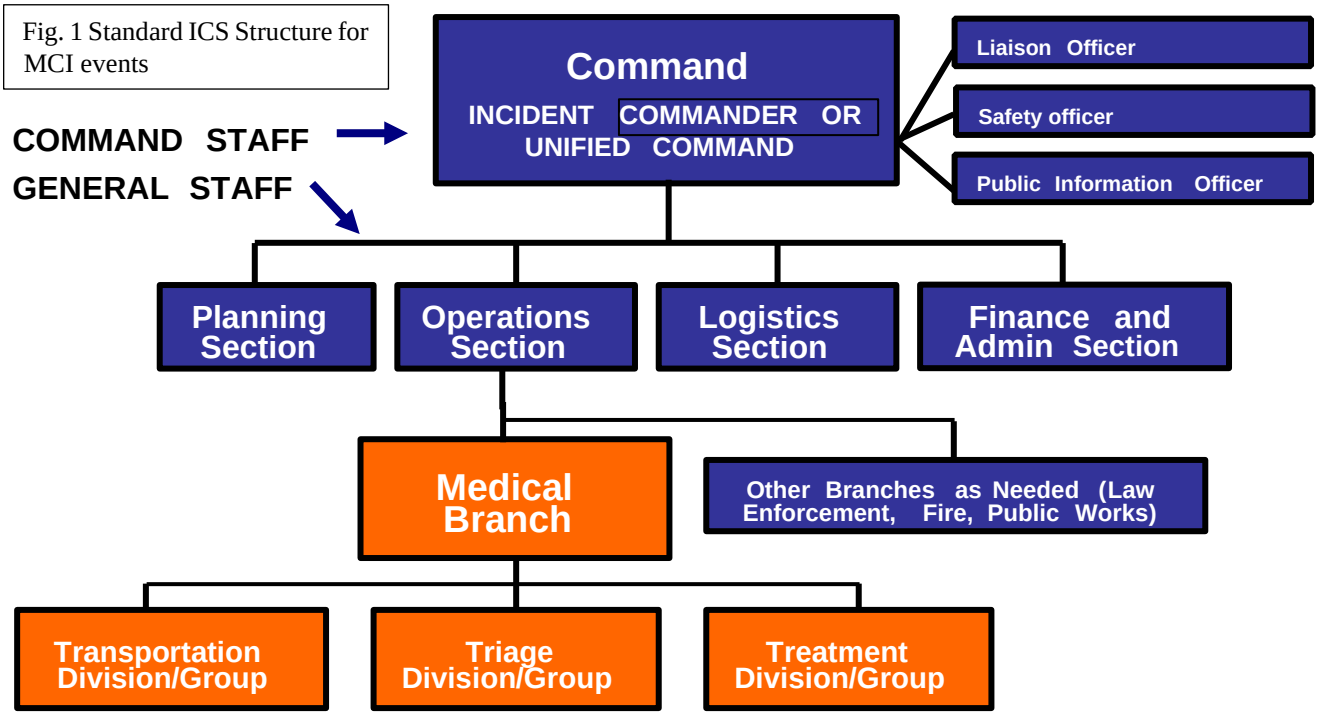
10. If the incident is a Chemical, Biological, Radiological, Nuclear or Explosive (CBRNE) mass casualty event it should be treated as a hazmat scene and if not already on scene, the appropriate hazmat team should immediately be contacted for assistance.

11. 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

Fig. 1 Standard ICS Structure for MCI events



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 talk group to utilize.

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

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. Triage Division/Group Supervisor (vest).

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

4. Transport Division/Group Supervisor (vest).

5. 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.

Medical Protocols

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

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. Law enforcement officials may act as the lead agency in a Unified Command structure if the MCI is determined to be of a hostile, intentional nature.

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

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

5. Providing security for the Rescue Task Force.

6. 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 Supervisor

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 Casualty Collection Point, 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).**

1. The five categories included are:

a. **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.

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

c. **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.

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

e. **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 Supervisor

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/Casualty Collection Point, where further, more extensive treatment may occur

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

1. Establishing a Treatment Area/Casualty Collection Point which is/should be:

i. During an Incident **NOT** identified as hostile
1. Is in a safe location
2. Away from the immediate action
3. Easily accessible for litter bearers transport units.

4. Large enough to accommodate all patients and medical personnel

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

ii. During a Hostile Event, in cooperation with LE (refer to HEIRT)

1. May be located in the warm zone

2. There may be multiple Casualty Collection Points

2. Sorting patients at the Treatment Area/Casualty Collection Point(s) to establish priorities for treatment and transport.

3. Tracking patients *(to the extent possible).*

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 Supervisor

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) in coordination with LE as appropriate

C. Tracking patients *(to the extent possible).*

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 *MARC HCC Response Plan* and applicable State plans **(Appendix B).**

VI. Emergency Communications

Radio Identification

A. Only essential radio communications should be made during a mass casualty incident.

B. All responding units will identify themselves on the radio with "Department Name - Unit Type - and Unit Number". For example, "I-35 command this is/from KC Medic 10."

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.

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

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

G. 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 objectives are switching primarily to exposure/confinement operations.

Use of the MARCER Radio System

A. The medical communications system 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 incoming patient situations.

B. The primary medical communications system is the Metropolitan Area Regional Radio System (MARRS). Every ambulance and hospital are 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.

Interoperable Communications Systems

In the event of EMResource failure, communications will follow local communications plans established by the Tactical Interoperable Communications (TIC) Plan.

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 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 (AAR) 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 G: Definitions

Appendix A: Regional EMS Resources

Regional resources and assets can be viewed in EMResource. For access to this platform or technical assistance, please contact MARC staff or the Duty Officer (913) 608-9425.

- EMS Region A Ground Services view *EMS Providers Region A* in EMResource
- Kansas City Metro and Missouri Region A Hospitals, including Northern and Southern Districts view *Missouri Hospitals* in EMResource

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 High Volume and Time Critical Diagnosis (TCD) diversion protocols, the plan describes a system of catchments for area hospitals. This system of catchments helps to ensure that if a hospital is experiencing 'high-volume-open' and/or is on TCD diversion, patients may be quickly routed to a nearby hospital in the affected hospital's catchment area.

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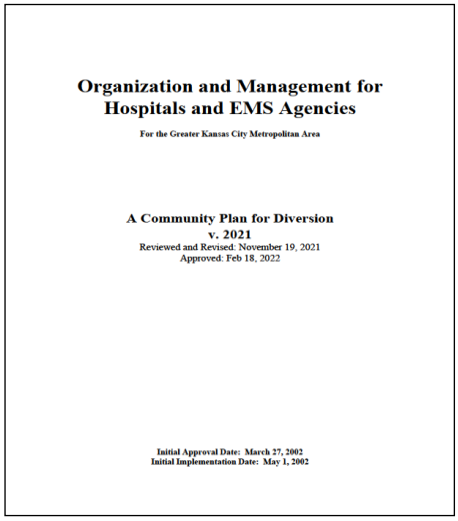

ESF 8*

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.

Kansas City Hostile Event Integrated Response Framework*

The Kansas City Hostile Event Integrated Response Framework outlines common practices and terminology for responding to intentional attacks. It is intended to provide guidance to help ensure that the myriad agencies likely to respond to the incident are working from the same assumptions and using collectively agreed upon terminology and techniques. This will allow for a better integrated response in order to expedite patient treatment and transport. This framework is meant to supplement, but never supersede, local plans and authorities; it is for the internal use of participating emergency services departments within the Kansas City metro region.

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.

Kansas City Tactical Interoperable Communication plan (TICP)*

This document establishes a Tactical Interoperable Communications Plan (TICP) for the Kansas City Urban Area. The TICP is intended to document the interoperable communications resources available within the designated area, who controls each resource, and what policies or operational procedures exist for the deployment and demobilization of each resource.

Mid-America Regional Council Health Care Coalition (MARC-HCC) Response Plan

This plan describes how elements of both the private and public sector health care will be coordinated and integrated into the comprehensive health and medical response efforts of the region. The plan is based on the utilization of the Regional Healthcare Coordination System (RHCS) and activation of the Regional Healthcare Coordination Center (RHCC) when needed. The plan provides the structure for a multi-facility and multi-jurisdictional responses within the region and coordinates response to incidents/events that exceed the capabilities of individual health care and/or jurisdictional entities by supplementing with regional, state and/or federal resources.

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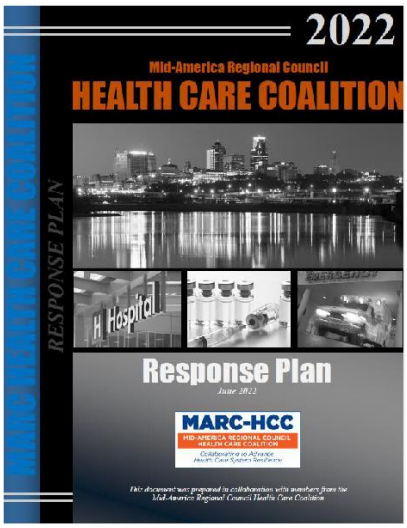

Missouri Statewide Patient Movement Plan

This plan describes how the Missouri Department of Health and Senior Services (DHSS), the State Emergency Management Agency (SEMA), and other State agencies work with and support the orderly movement of patients from hospitals or a large-scale incident using EMS resources activated through state requests from hospitals, healthcare systems, regional healthcare coalitions and/or local government emergency operations centers in response to a significant incident within the State.

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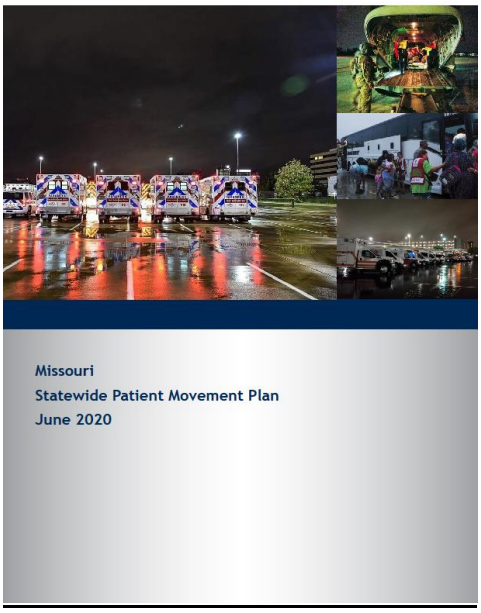

Missouri Systems Concept of Operational Planning for Emergencies (MoSCOPE)

The foundation for mutual aid in the State of Missouri. This All-Hazards Plan is a template for all response partners to coordinate effect and efficient response for those in need. This plan is designed to support local emergency officials during large scale events and expanding incidents when additional resources are needed.

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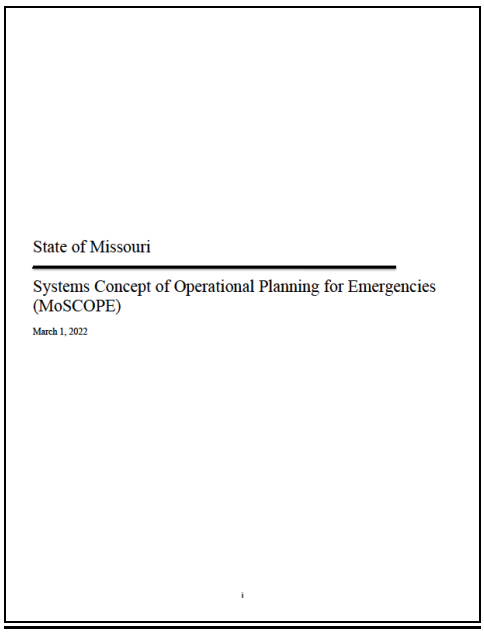

State of Missouri

Systems Concept of Operational Planning for Emergencies (MoSCOPE)

March 1, 2022

Northeast Kansas Health Care Coalition Response Plan

The purpose of this Plan is to provide general guidance for planning, response, and recovery to all events, both naturally occurring and man-made that result in illness or injury to the population within and threaten the healthcare system in Northeast Kansas.

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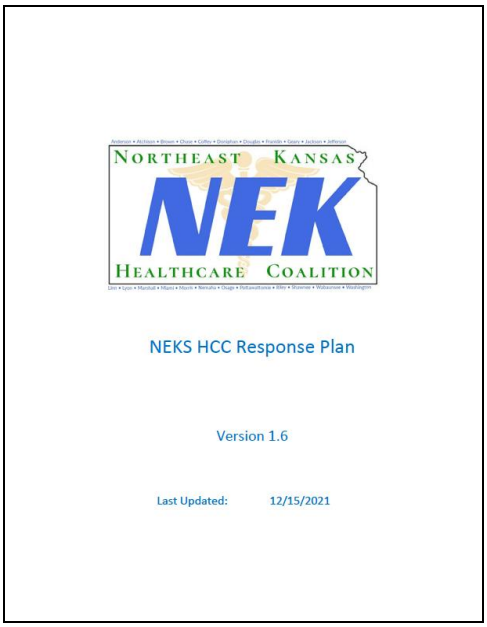

NORTHEAST KANSAS NEK HEALTHCARE COALITION

NEKS HCC Response Plan

Version 1.6

Last Updated: 12/15/2021

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.

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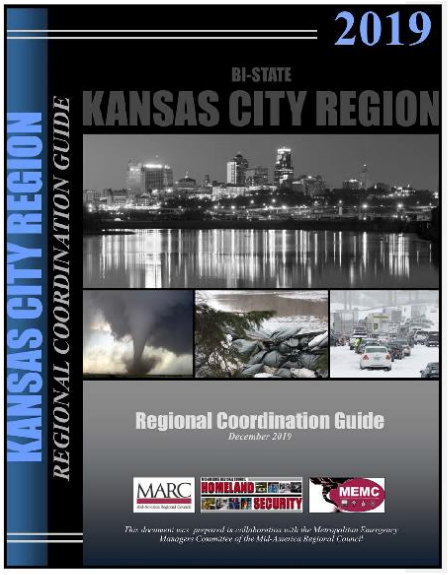


Regional Hazardous Materials Emergency Preparedness Plan*

Provides an administrative framework for hazardous materials planning and response in the Missouri counties served by the Missouri Region A Urban Local Emergency planning District (LEPD)and the Kansas counties that comprise the Kansas 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.

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 MARC Staff or the Duty Officer (913) 608-9425.***

Appendix C: Incident Command System Positions Descriptions

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.).

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

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.

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

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.

Medical Staging Officer (Ground or Air)
Responsible for managing all medical activities within the staging area.

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

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

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.

Staging Area Manager
Responsible for managing all activities within the staging area.

Transport Division/Group Supervisor

Responsible for:

a. arranging appropriate vehicles for patients requiring transport
b. Securing ambulance ingress and egress route(s) in coordination with LE, as appropriate
c. Tracking patients *(to the extent possible)*
d. Communicating with the EMCC to determine hospital availability/capacity
    a. *Please see consideration in checklist below*

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.

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.

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

☐ 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

TRIAGE DIVISION/GROUP SUPERVISOR

☐ 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

TRANSPORTATION DIVISION/GROUP SUPERVISOR

Important consideration: While coordinating transport from the scene of an MCI, during more recent events, it has been evident that hospitals in the immediate vicinity of the scene are likely to receive the bulk of patients delivered by means other than EMS (personal vehicles, pedestrian traffic, law enforcement, etc.). For this reason, consideration should be given to the immediate capacity of those hospitals closest to the event, their ability to take critical patients and the eventual (if not immediate) need to decompress those facilities.

- ☐ 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 *(to the extent possible)* 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.

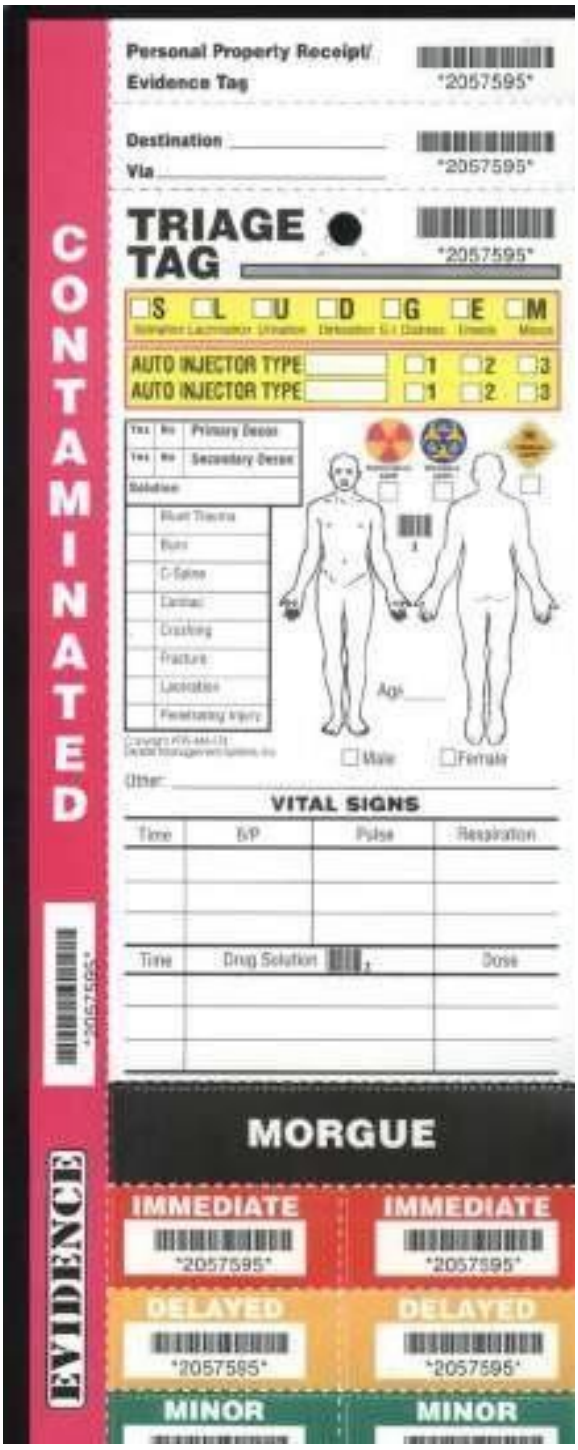
B. Patient Tracking should be pre-planned for any known mass gathering.

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.

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. An example of a triage tag is illustrated on the following page. If possible, a digitally coded triage tag should be utilized to assist in patient tracking.

F. The Transportation Division/Group Supervisor will make the information available to other requesting agencies for reunification as appropriate.


CONTAMINATED
Personal Property Receipt/
Evidence Tag
2057595
Destination
Via
TRIAGE TAG
S L U D G E M
AUTO INJECTOR TYPE
AUTO INJECTOR TYPE
Primary Decon
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
IMMEDIATE
DELAYED
DELAYED
MINOR
MINOR
EVIDENCE


Comments/Information
Patient's Name
RESPIRATIONS
Yes
No
PERFUSION
+ 2 Sec
- 2 Sec
MENTAL STATUS
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
PERSONAL INFORMATION
NAME
ADDRESS
CITY
ST
ZIP
PHONE
COMMENTS
RELIGIOUS PREF
MORGUE
Pulseless/Non-Breathing
IMMEDIATE
Life Threatening Injury
IMMEDIATE
Life Threatening Injury
DELAYED
Serious Non Life Threatening
DELAYED
Serious Non Life Threatening
MINOR
Walking Wounded
MINOR
Walking Wounded
CONTAMINATED
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:

MARCER
One trailer available: Located at Central Jackson County Fire Protection District Education Facility
Contact: Central Jackson County Fire Protection District or call KCFD Dispatch Asst. Div. Chief (816) 923-7453

- 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
One trailer available in Olathe
Contact: Johnson County Emergency Communications Center at (913) 432-2121

- Capacity to treat up to 50-75 patients
- ALS and BLS equipped

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. For other regional assets, please see the Regional Resource Annex.

Appendix G: Definition of Terms

Significant regional effort has been taken to limit and standardize the use of terminology throughout all emergency response plans and frameworks. However, there remains a significant cross-section of disciplines responding to larger incidents, and variations in terminology continue to exist. This Annex is intended as a reference crosswalk that might help inform and clarify various terminology.		**Plan Specific Definition Key**			
Term	**Definition**	**Hostile Event Integrated Response Training (HEIRT)**	**Regional Hostile Events Framework (RHEF)**	**Regional Mass Casualty Incident Plan (RMCIP)**	**Can apply to all plans**
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 objectives are switching primarily to exposure/confinement operations			**X**	

Ambulance Exchange Point	a secure location in the warm zone where patients are loaded onto an ambulance for transportation. Fire apparatus could potentially be used to provide cover.	**X**			
Ambulatory (Walking Wounded) Patient Area	the location, typically in the Cold Zone, that ambulatory patients will be directed to for interview, assessment, and transport.				**X**
Area of Safe Refuge	An area completely free of immediate threat of danger or bodily harm, located in the Cold Zone.				**X**
Casualty Collection Point	the location in the Warm Zone where victims can be assembled for transport (critical patients) or movement to the triage/treatment area (non-critical patients) in the Cold Zone. Potentially contaminated patients should be isolated from non-contaminated patients prior to reaching the Casualty Collection Point. Multiple Casualty Collection Points may be required for a large venue. Each Casualty Collection Point should have at least one armed Law Enforcement Officer (LEO). Casualty Collection Point locations and names should be communicated.				**X**
Casualty Collection Point Boss	Medical personnel designated to communicate with unified command about number and status of victims. Also communicates and coordinates RTFs as they arrive.	**X**			
Contaminated Patient	a person that has been exposed to a chemical or biological agent. These patients must be separated from non-contaminated patients and kept at the Warm/Hot Zone border for decontamination.				**X**

Critical Patient	a patient at eminent risk of dying secondary to sustained injury or inflicted illness. These patients are most typically triaged as "Immediate (Red)."		**X**		
EMResource	on-line reporting system that Kansas City area hospitals use to keep Public Safety Communications Centers updated on their status. A poll of this system during a mass casualty incident allows the hospital to tell the Communications Centers how many patients of what acuity they can take.				**X**
Evacuate/Abandon	directs all responders to immediately leave the area, dropping in place any equipment that would slow down retreat. Personnel accountability must be assured after this command has been given.			**X**	
Family and Friends Notification, Reception Center (FFNRC)	The FFNRC provides initial limited services and support while the Family Assistance Center (FAC) is being established. The first phase consists primarily of providing information, family notifications, patient tracking, and injury/fatality notification.				**X**
Hall Boss	a Law Enforcement Officer who ensures priority of fire/EMS in the hallway during a hostile event inside a structure. Ensures positive linkups with arriving resources, communicates and coordinates with causality collection point and unified command on evacuation to the ambulance exchange points	**X**			
Hot Zone	the operational (geographical) area consisting of the specific incident location as well as the immediate surrounding area, where an immediate threat				**X**

	exists, that has not been secured by Law Enforcement. If the Hot Zone perimeter is established by Fire/EMS, it will be accepted/ adjusted by Law Enforcement in a timely manner. It may be considered an Immediately Dangerous to Life and Health (IDLH) environment due to projectile, chemical or explosive threats. Typically, only specialty team Fire/EMS providers will be in this area with Law Enforcement escort.				
Indirect Threat Care	care provided when the threat is suppressed in the Warm Zone of the incident.	**X**			
Law Enforcement Contact Teams	may be comprised of 1-4 Law Enforcement personnel responsible for locating, engaging and/or eliminating the threat.	**X**			
Life Safety	A term utilized by Fire, EMS and Law Enforcement disciplines. The term identifies the levels of risk which may be employed in the resolution of a situation. For Law Enforcement, the levels are generally identified as innocent, uninvolved citizens, involved citizens, first responders and then suspects. For the Fire/EMS responder community the term may be summarized by a Risk Management Philosophy which states: "We begin each response with the belief that we can save lives and property." Further, "we may assume a significant risk to save a known life; we may assume a calculated risk, and provide for additional safety, to reduce the potential for civilian and emergency responder injuries and/or save property. We will assume no risk in an				**X**

	effort to save that which is already lost."				
Media Reception Area	located in the Cold Zone where the media will meet with Public Information Officers (PIO) and possibly members of the Command Staff for periodic information updates (press conferences).				**X**
Non- Critical Patient	a patient **NOT** at eminent risk of dying secondary to a sustained injury or inflicted illness. These patients are typically triaged as "Delayed (Yellow)," or "Minor (Green)."		**X**		
Non-Normal Mutual Aid Partner	Agency with which another may or may not have a formal mutual aid agreement with and does not routinely operate with.		**X**		
Notification Area	located in the Cold Zone, typically a distance away from the scene, where family, friends, and other bystanders can be assembled to receive information and reunification with ambulatory patients/non-injured subjects.		**X**		
Perimeters	established at the scene of any major event and provide a significant aspect of controlling the event and returning conditions to normal. Perimeters are defined by the nature of the event. The purpose of setting perimeters is to minimize and/or eliminate the 'chaos' that significant events which come to the attention of the public may produce. Perimeters also serve to protect citizens involved, citizens responding or attempting to respond into the event venue and the first responders coming to the event.		**X**		

Plain Clothes First Responders	most likely from the Law Enforcement discipline, however, may represent any traditional first responder discipline and a variety of jurisdictional levels to include local, county, state, federal and both Johnson County jurisdictions and non-Johnson County jurisdictions. On duty responding personnel must make every effort to identify, control and likely work with this identified group of well-intentioned responders.		**X**		
Recon Task Force	Should consists of 1-2 Law Enforcement Officer and 1-2 Fire/EMS personnel formed to enter the Warm Zone to initiate a rapid patient count by triage type and establish a Casualty Collection Point. Treatment by the Recon Task Force should be limited to basic airway maneuvers	**X**	**X**		
Rescue Task Force	Should consist of 1-3 armed Law Enforcement Officers (LEO) (Security Element), 2-4 Fire/EMS members (or other combinations of personnel as available), preferably with at least 1 paramedic (Medical Element) and a team leader (typically law enforcement). It will be responsible for moving into the Warm Zone; proceeding to the edge of the Hot Zone; and initiating triage and evacuation of the patients to the Casualty Collection Point(s).	**X**	**X**		
Secure Area	area with controlled access that is limited or protected by physical security such as armed guard. In an active shooter scenario this would include a casualty collection point with armed police security, or lockable doorway that cannot be breached. This				**X**

	could occur inside a Warm Zone of the building once the initial threat has been neutralized or isolated to a different part of the building, ***but prior to the entire area being deemed safe.***				
Staging Area	a temporary area for available resources to be placed or parked while awaiting an operational assignment. This may be closer to the scene than Staging Area and could be in the Warm Zone.	**X**	**X**		
Stimulus	the point of distraction, chaos and unknown indicators.	**X**			
Task Force	a combination of single resources assembled for a particular tactical need with common communications and a leader.	**X**	**X**		
Unsecure Area	a location that is inadequately guarded / protected or where Law Enforcement has not performed a primary search. The Hot Zone is an example of an unsecure area.		**X**		
Warm Zone	the secure operational (geographical) area that can be accessed by Fire/EMS responders with Law Enforcement escort in order to facilitate the removal of victims. The size of the Warm Zone may expand or contract depending on the circumstances of the incident. The Warm Zone surrounds the Hot Zone. It is a secure area that can be accessed by Fire/EMS responders with Law Enforcement escort in order to facilitate the removal of victims.				**X**
Withdraw	indicates responders should, in an orderly manner, back out of the area, taking all equipment in the process.			**X**	