2019

MASS CASUALTY INCIDENT PLAN

BI-STATE

KANSAS CITY REGION

Regional Mass Casualty Incident Plan

MARCER MCI PLAN

MID-AMERICA REGIONAL COUNCIL
EMERGENCY RESCUE COMMITTEE (MARCER)

REGIONAL
MASS CASUALTY
INCIDENT PLAN
FOR METROPOLITAN KANSAS CITY

June 2019

I. Record of Changes 5
II. Letter of Promulgation 6
III. Overview 7
IV. Implementing the Mass Casualty Incident Plan 10
V. Triage Treatment and Transport Procedures 12
VI. Emergency Communications 15
VII. MCI Equipment Caches 17
VIII. Pre-incident and Post-incident Activities 18
IX. Appendices 18

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**

II. Letter of Promulgation

To All Agencies and Readers:

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

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

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

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

III. Overview

Background

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

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

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

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

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

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

Purpose

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

1. Increase knowledge and access to available resources.
2. Improve understanding and enhance coordination in the use of the region's various medical communications systems.
3. Standardize equipment and training.
4. Offer consistent definitions for Incident Command System operations at an MCI.
5. To coordinate resources in the event of an MCI, either live or virtual through WebEOC.
6. The use of a regional plan allows for command staff from other agencies to be utilized in the incident organization to fill ICS positions and free up ambulance crews for triage, treatment and transport tasks.

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

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

Regional Coordination

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

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

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

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

Definitions

A. Mass Casualty Incident

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

MCI Level Definitions:

MCI Levels
Level V – 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 – 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 – 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 talk group on the regional radio system.
Level II – 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 talk group on the regional radio system.
Level I – 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 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 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. 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

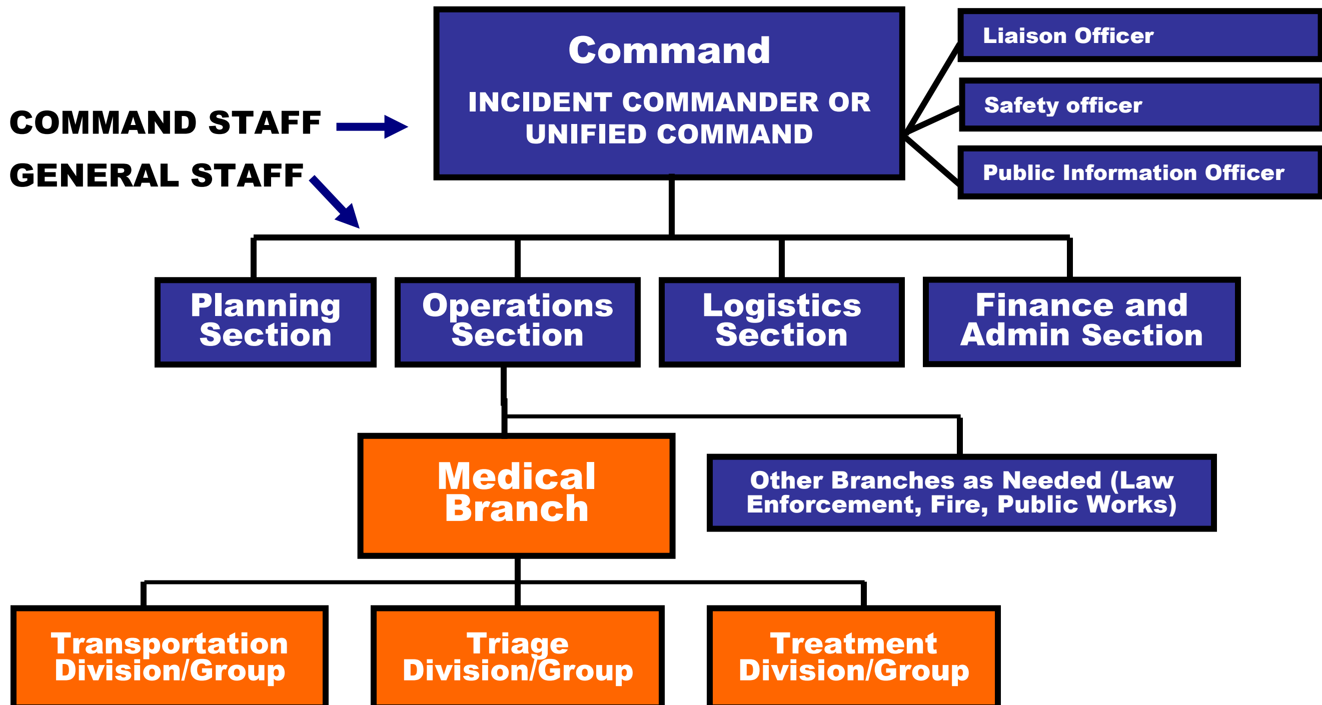
Initial Incident Priorities

1. Assess the scene and check for unusual hazards and/or threats (e.g. hazardous materials, active shooter, etc.)
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 command/unified command and announce location.
6. Assign or initiate triage.
7. Establish patient tracking early.
8. If the incident is a Chemical, Biological, Radiological, Nuclear or Explosive (CBRNE) mass casualty event it should be treated as a hazmat scene and if not already on scene, the appropriate hazmat team should immediately be contacted for assistance.
9. If a CBRNE incident, the EMCC should note the need for decontamination and issue a Haz-Mat / MCI Alert in order to poll hospitals for their capability for decontamination.

EMResource Control Centers:

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

Figure 1: Sample ICS Structure for Mass Casualty Incidents



When contacting mutual aid agencies, provide the following:

A. Nature and location of the emergency.

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

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

D. Appropriate regional communications talkgroup to utilize.

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

Medical Branch Functions and Personnel

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

1. Medical Branch Director (vest).

2. 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. 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 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 treatment or transport 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 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.

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 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).

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 MARC HCC Response Plan and applicable State plans.

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, **"KC MEDIC 10 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.

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

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

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

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

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

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

Use of the MARCER Radio System

A. The medical communications system 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 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 on the number of patients being transported and to which hospitals.

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

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

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

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

Interoperable Communications Systems

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

VII. MCI Equipment Caches

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

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

VIII. Pre-incident and Post-incident Activities

Review of Mass Casualty Incidents

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

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

Training and Exercises

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

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

IX. Appendices

Appendix A: Regional EMS Resources

Appendix B: Regional Plans Index

Appendix C: ICS Position Descriptions

Appendix D: ICS Position Checklists

Appendix E: Patient Tracking with Scan ID Triage Tag

Appendix F: Regional Equipment Caches

Appendix A – Regional EMS Resources

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

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

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

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

REGIONAL HOSPITALS

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

	Lawrence, KS 66044	
KANSAS		
Miami County Medical Center	2100 Baptiste Dr. Paola, KS 66071	913/294-6655
Menorah Medical Center	5721 W. 119th Street Overland Park, KS 66209	913/498-7707
Overland Park Regional**	10500 Quivira Road Overland Park, KS 66215	913/541-5946
Providence Medical Center	8929 Parallel Kansas City, KS 66112	913-596-4000
Olathe Medical Center	20333 W. 151st Street Olathe, KS 66061	913/791-4200
Saint Luke's South Hospital	12300 Metcalf Ave. Overland Park, KS 66213	913/317-3477
Saint John Hospital	3500 So. Fourth St. Leavenworth, KS 66408	913/680-6000
Shawnee Mission Medical Center	9100 W. 74th St. Shawnee Mission, KS 64204	913/676-2208
University Of Kansas Hospital*	3901 Rainbow Blvd. Kansas City, KS 66160	913/588-0393

NON-REGIONAL HOSPITALS

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

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

Appendix B – Regional Plans Index

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

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

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

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

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

Regional Public Health Emergency Plan Missouri Region A

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

Missouri Bioterrorism Region A Hospital Plan

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

Kansas Regional Hospital Plan – Northeast Kansas Region

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

Mid-America Local Emergency Planning Committee (LEPC) Plan

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

Regional Coordination Guide

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

Local Plans

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

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

Appendix C – Incident Command System Positions Descriptions

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

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

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

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.

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

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.

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 atriage 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 ____________ *2057595*

Via ____________

TRIAGE TAG

2057595

☐ S Salivation ☐ L Lacrimation ☐ U Urination ☐ D Defecation ☐ G G.I. Distress ☐ E Emesis ☐ M Miosis

AUTO INJECTOR TYPE ____ ☐ 1 ☐ 2 ☐ 3

AUTO INJECTOR TYPE ____ ☐ 1 ☐ 2 ☐ 3

Yes	No	Primary Decon
Yes	No	Secondary Decon
Solution		

Radiological Agent ☐ Biological Agent ☐ Chemical Agent ☐

- Blunt Trauma
- Burn
- C-Spine
- Cardiac
- Crushing
- Fracture
- Laceration
- Penetrating Injury

Age ____

☐ Male ☐ Female

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Other: ____________

VITAL SIGNS

Time	B/P	Pulse	Respiration

Time	Drug Solution	Dose

2057595

EVIDENCE

MORGUE

IMMEDIATE *2057595*	IMMEDIATE *2057595*
DELAYED *2057595*	DELAYED *2057595*
MINOR *2057595*	MINOR *2057595*

Comments/Information

Patient's Name

RESPIRATIONS	PERFUSION	MENTAL STATUS
R ☐ Yes ☐ No	P ☐ + 2 Sec. ☐ - 2 Sec	M ☐ Can Do ☐ Can't Do

- Move the Walking Wounded ▶ **MINOR**
- No Respirations After Head Tilt ▶ **MORGUE**
- ☐ Respirations - Over 30 ▶ **IMMEDIATE**
- ☐ Perfusion - Capillary Refill Over 2 Seconds ▶ **IMMEDIATE**
- ☐ Mental Status - Unable to Follow Simple Commands ▶ **IMMEDIATE**
- Otherwise ▶ **DELAYED**

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PERSONAL INFORMATION

NAME		
ADDRESS		
CITY	ST	ZIP
PHONE		
COMMENTS	RELIGIOUS PREF.	

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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:

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 equippe

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.