Nonurban Missouri Healthcare Coalition Infectious Disease Annex

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Name	Title	Date	Summary of Changes

INTRODUCTION

Missouri's Nonurban health care coalition (HCC) covers a large geographic area including 92 Missouri counties (out of 115 counties) including both rural and small metropolitan areas and has a population of nearly 2,500,000 people. The diverse population, combined with the potential for a variety of hazards including severe weather, earthquakes, hazardous material incidents, and large planned events places the region at a significant risk for a disaster impacting health care resources, assets and the ability to offer and sustain health care services to the nonurban Missouri population.

Purpose

This plan provides the framework to guide the nonurban Missouri health care coalition (HCC) to respond to infectious disease incidents among diverse health and medical entities supporting ESF-8 functions within the coalition's boundaries.

The HCC's primary role in response is to represent member organizations through multi-agency coordination and to support organizational incident management through information and resource coordination. This requires coordination among a broad spectrum of health care providers to include but not limited to hospitals, local public health agencies, emergency medical services and emergency management. HCC preparedness and response structures also incorporate representation from the 17 provider and supplier types outlined in the Centers for Medicare and Medicaid Conditions of Participation, mental/behavioral health providers, community and faith-based partners, as well as state and local governments.

All emergencies require a coordinated approach in which multiple disciplines and organizations, both public and private, work together. The health care coalition serves as the body to coordinate the response among a diverse group of healthcare organizations. This role is essential given that disasters often necessitate public health and medical response.

Scope

This plan applies to all nonurban Missouri health care coalition members when an event occurs that is beyond an individual healthcare organization's ability to manage the response. This plan does not dictate organizational response, nor does it supersede or conflict with jurisdictional or agency responsibilities, applicable laws and statutes. The nonurban Missouri health care coalition facilitates information sharing and coordination, but not direction and control, as there is no statutory authority governing the HCC.

The Nonurban Missouri Health Care Coalition Response Plan will be managed and maintained by Missouri Hospital Association on behalf of the nonurban Missouri HCC. MHA will update this plan following an exercise or real world event, or at least once annually with guidance from by the nonurban Missouri HCC Leadership Board. The plan will be reviewed and accepted by all HCC members. Participating members are responsible for updating their respective facility EOPs

Overview/Background of HCC and Situation

Assumptions

All frontline healthcare facilities, including any facility equipped for emergency care, such as hospital-based emergency departments and other emergency care settings including urgent care clinics and

critical access hospitals, shall maintain procedures consistent with [Diseases and Conditions Reportable in Missouri](#) (19 CSR 20-20.020). Diseases and Conditions shall be reported to their local health agency or to: Missouri Department of Health and Senior Services during business hours 573-751-6113, after hours and on weekends 800-392-0272 or by fax 573-526-0235.

DHSS will resume actively disseminating information similarly should the need arise.
Missouri partners will utilize the National Incident Management System (NIMS) and Incident Command System (ICS) to coordinate operations.

Missouri maintains a protected view in EMResource indicating the availability, quantities, locations and points of contact for each location of PPE. This view is available continuously to healthcare coalition leaders, select specialty care transport agencies and state-level designees to assure updated information is available when required.

Just-in-time caches of PPE are available for use by any frontline healthcare facility, EMS or public health agency. An assessment of regional resources, considering the scenario, will be conducted prior to requesting deployment of such caches. Health care organizations anticipating a shortage should notify their emergency management director and health care coalition duty officer at their earliest convenience.

Planning Assumptions for Bioterrorism
- All hospitals with emergency departments are designated as "first Receiver" facilities for Chemical, Biological, Radiologic, Nuclear and Explosive (CBRNE) Incidents and are equipped to respond to an initial threat or incident.
- All frontline healthcare facilities, including any facility equipped for emergency care, such as hospital-based emergency departments and other emergency care settings including urgent care clinics and critical access hospitals, shall maintain procedures to quickly identify and isolate patients with possible infectious disease. This shall include maintaining adequate personal protective equipment (PPE) compatible with patient care for at least 24 hours.

Planning Assumptions for Infectious Disease
- All frontline healthcare facilities, including any facility equipped for emergency care, such as hospital-based emergency departments and other emergency care settings including urgent care clinics and critical access hospitals, shall maintain procedures to quickly identify and isolate patients with possible infectious disease. This shall include maintaining adequate personal protective equipment (PPE) compatible with patient care for at least 24 hours.
- Some healthcare systems within the state may elect to transport a PUI to another hospital within their healthcare system prior to a decision to transport to the state-designated assessment hospital or while awaiting transport to the state-designated assessment hospital (should one be designated), due to capacities at frontline healthcare facilities within the healthcare system.

- Missouri healthcare coalitions, including EMS, frontline healthcare facilities involved, Barnes-Jewish Hospital and the University of Kansas Hospital System as the state-designated assessment hospitals, and DHSS will coordinate resources and communications through EMResource and eICS, as well as telephonic communication.
- All individuals involved in the planning or actual movement of the patient shall have the ability to stop the process should they perceive a safety concern without fear of punishment or personnel action. Any such decision must be immediately reported and discussed with appropriate organizational or facility hierarchy, public health and healthcare systems partners and DHSS to assure responder safety/health, as well as continued and appropriate patient care.
- Missouri is implementing the tiered approach to patient care as outlined by the [CDC Interim Guidance for U.S. Hospital Preparedness for Patients Under Investigation (PUIs) or with Confirmed Ebola Virus Disease (EVD): A Framework for a Tiered Approach](#).
- Persons reported with nationally defined risk factors for highly infectious disease will be under active or direct active monitoring by a local public health agency (LPHA) which is routinely communicating a providing updates to the DHSS.
- Persons with reported risk factors for Highly Infectious Disease who develop consistent signs or symptoms for the disease will be designated a Person Under Investigation (PUI).
- The LPHA will assure the patient is informed they should not self-refer to the assessment hospital nor a frontline healthcare facility, but coordinate a decision to seek patient care through the monitoring LPHA.
- Should a PUI determine to seek patient care, the LPHA will appropriately notify the regional healthcare coalition and respective frontline healthcare facilities, as appropriate.
- It is recognized that not every patient will be compliant with this request, thus all partners should recognize that a PUI may present to the hospital for assessment and/or treatment via the emergency department, ambulatory clinic, at/or through the state or local public health department.
- All frontline healthcare facilities, including any facility equipped for emergency care, such as hospital-based emergency departments and other emergency care settings including urgent care clinics and critical access hospitals, shall maintain procedures to quickly identify and isolate patients with possible Ebola or another highly infectious disease. This shall include maintaining adequate personal protective equipment (PPE) compatible with caring for a patient with highly infectious disease for at least 24 hours.
- PPE caches consistent with the care of EVD PUIs have been placed with select, specialty care transport agencies which have volunteered to provide transport to PUIs.
- Some healthcare systems within the state may elect to transport a PUI to another hospital within their healthcare system prior to a decision to transport to the state-designated assessment hospital or while awaiting transport to the state-designated assessment hospital, due to capacities at frontline healthcare facilities within the healthcare system.
- Highly infectious Disease planning addresses a relatively small number of infectious patients. Crisis Standards of Care and Pandemic Plans will be leaned upon should a larger incident present itself.

Concept of Operations

Activation

The coalition will function in a decentralized nature during normal day-to-day activities. As an incident or event occurs with potential or actual impact to coalition members, the coalition may be placed on advisory, alert or activated status using the EMResource® and eICS® platforms. Notification to the HCC members through these systems is critical to ensure timely situational awareness and to inform other coalition members of real-time situations, activities, current and projected actions to mitigate the threat and/or manage the incident.

Because of the widespread geography of nonurban Missouri and the main responsibilities of healthcare coalition members residing at the organization level, primary coalition communication and coordination should occur virtually through sequential and redundant methods of communication accessible to all HCC members. Depending on the incident and resource demands on the healthcare infrastructure, face-to-face coordination may be deemed appropriate to increase response effectiveness and efficiency.

The following are a description for each coalition status, listed in the order of escalation, with "activation" being the most robust operational status. (MSCC, 2007; MSCC, 2009). Current statuses for regions of the coalition can be located in EMResource. The coalition can determine which Juvare systems are appropriate for response based on the nature of the incident. Coalition status should be updated in EMResource for each level. The coalition must use an eICS event for communication and coordination for an activation. The coalition may choose to use an eICS event for an advisory or alert, if deemed appropriate for the situation.

Monitoring

A monitoring status provides urgent information about an unusual occurrence or threat of an occurrence, but no action by the message recipient is expected. A monitoring status may include actionable information for individual personnel at healthcare organizations even though the organizations may not need to take emergency action.

MHA monitors federal queries and activations including Midwest-1 DMAT and FEMA's national ambulance contact and will advise regions of any anticipated impacts.

On Alert

This status is used when coalition resources have been notified of potential events that may lead to full activation. An alert provides urgent information and indicates that some action on the part of the message recipient may be necessary. No immediate response or deployment is necessary. This category also may be used for ongoing notification during an emergency to convey urgent information and recommended actions.

Active

This status is used when a response from coalition members is required. Coalition procedure triggers the notification through EMResource® and the activation of eICS to assign coalition members to appropriate response roles.

Notification

Activation and notification will occur through EMResource and eICS platforms. Follow-up communication will occur through various channels as appropriate such as email, text messages, and radios as appropriate to the incident.

Roles and Responsibilities

HCC members are classified as either a primary or support, with their outlined roles and responsibilities laid out in the Nonurban HCC Response Plan. Specific to the areas of infectious disease, each HCC member is expected to contribute as they can situational awareness, disease surveillance, information sharing, best practices and their ability to contribute to coalition projects and needed resources.

Operational Mission Areas

Operational mission areas are primarily situational awareness, information sharing and operation response coordination and support. The level to which each entity can contribute is determined by the amount of impact on the entity. Those entities who are not overwhelmed should offer support and assistance as they are trained and able. Coordination of resources can be offered to coalition partners.

Response Actions

The regional nonurban healthcare coalitions have adopted the following response objectives. (Barbera & Macintyre, 2009, pg. 2-2)

- "Facilitate the interface between the healthcare coalition and relevant jurisdictional authorities to establish effective support for healthcare system resiliency and medical surge."
- "Facilitate the coordination of incident response actions for the participating healthcare organizations so incident objectives, strategy and tactics are consistent for the healthcare response."
- "Facilitate information sharing among participating healthcare organizations and jurisdictional authorities to promote common situational awareness."
- "Facilitate resource support by expediting the mutual aid process or other resource sharing arrangements among coalition members and supporting the request and receipt of assistance from local, State and Federal authorities."

Initial HCC Actions
Information Gathering

The health care coalition establishes the necessary incident command structure based on the scale and scope of the incident and begins to gather essential elements of information from coalition members (see essential elements of information section). This information is either gathered through EMResource/eICS or is shared by the HCC in EMResource/eICS so all members have access to necessary information.

Information gathered is validated and shared to promote situational awareness of coalition members and other resource partners. The HCC continues to gather and validate information to determine if the situation has escalated or warrants additional action.

Ongoing HCC Actions
Information Sharing

As a response to an incident continues, the HCC continues their role in gathering and sharing appropriate information and needs to form two-way communication between healthcare organizations and the coalition.

Resource Coordination

As the response warrants, the HCC identifies resource needs of its members and helps coordinate filling those needs. Resource Coordination will follow guidelines in the resource coordination section of this plan.

Integration with Other Response Efforts

In addition to forming two-way communications between organizations and the coalition, the coalition serves as the liaison with other response efforts including other health care coalitions and at all levels of government.

Essential Elements of Information

Healthcare coalitions, healthcare organizations, emergency management, relevant response partners and stakeholders coordinate to determine reportable healthcare incident specific information to be used during response. This information identifies the essential elements of information that can be reasonably shared during an incident. Based on the scope and scale of the incident, appropriate essential elements of information will be collected from local, regional and state partners to support the response needs. The primary tool to collect information from healthcare partners will be EMResource® and eICS. EMResource has pre-scripted queries to collect bed availability and resources at both the regional and state level. Members can contact the duty officer to request a query be initiated.

It is critical that two-way communication of this information is established. Additional information may need to be shared depending on the nature of the incident.

Healthcare Organization Status Information Needed by HCC

Healthcare organizations should share, but are not limited to, the following elements:
- Patient capacity
- Staffing levels
- Facility capabilities
- Casualty estimates
- Specialty services available or needed

Information Provided by HCC

The HCC should provide should share, but are not limited to, the following elements:
- Incident location and details
- Communication and reporting timeline
- ESF8 objectives

Following a catastrophic incident resulting in long term coordination, additional information needs to be shared. The chart below includes those pieces of essential elements of information that need to be shared by members to the coalition and from the coalition to members and the timeframe it should be shared within.

Information Provided from <u>Members</u> to <u>Coalition</u> Following Catastrophic Incidents

4 Hours Post Incident	12 Hours Post Incident	24 Hours Post Incident
•CAN Report (Current Condition, Actions Taken, Needs) •Operational Status - Are you remaining open? •Power/Fuel •Water •Oxygen (bulk, portable) •Life Safety/Infastructure •Biohazard •Structural assessment •Functional communication platforms •Situational assessment (open-ended)	•Facility Operations •Communications Infastructure •Critical Facility Damages •Security On Scene - what needs secured/cyber •Facility Evacuation (coordinate due to surge - self transport and structured evacuation) •Patient Care •Capabilities •What can be shared? •Casualty Report •Self sustaining? Food/water •Location of Alternative Care Sites •Needs	•Patient Rosters - movement or sustainment •Surge Information •Supplies Needed to Maintain Operations •Staff Needs and Rosters (with credentials)

Information Provided from <u>Coalition</u> to <u>Members</u> Following Catastrophic Incidents

4 Hours Post Incident	12 Hours Post Incident	24 Hours Post Incident
•Who have we not heard from? •Official Incidnet and Operational Periods •Summary Report •Transportation Routes •Arrival of Supplies (include push locations)	•1135 Waivers •Collection Points •Talking Points to Distribute •State Situation Report •Public Shelter Locations • Transportation Routes •Arrival of Supplies •Summary of Facility Statuses and Bed Availability	• Continued Situational Reports

Public Information Officer (PIO)/Joint Information Center (JIC)

The coalition does not have a formal PIO. The coalition should coordinate with the local and regional JIC, if activated, and individual healthcare organization PIOs.

Resource Coordination

Role of HCC in Resource Coordination

Healthcare organizations should first try to meet resource needs internally and at the local level. If resource needs cannot be met locally, the coalition should be notified and will assist in finding and coordinating resources. In accordance with NIMS, the HCC will coordinate all requests for additional assistance with the local jurisdiction. If the county cannot fulfill the request, the county will submit a request to the state. If the state cannot fulfill the request using its resources or through the Emergency Mutual Aid Compact (EMAC), they will submit a request to FEMA.

Surveillance

Each region of the Nonurban HCC will request participation from their state Epidemiologist at their regularly scheduled meeting. HCC members who are experiencing outbreaks will be encouraged to provide awareness level information to other coalition members. Clinical SMEs will be tasked with monitoring for local, state, national and international outbreaks or concerns. Security SMEs and / or HAZMAT SMEs will be tasked with providing awareness of risks and events related to biological terrorism or attack. Platforms such as ESSENCE data will be utilized as available and appropriate.

Safety and Infection Control and Prevention

Maintaining partnerships with organizations such as ASHRE and MOSHE are of profound importance as all efforts to maintain life safety codes are crucial to the implementation of a sustainable response. In addition, these SMEs are able to inform and relay best practices and techniques related to engineering barriers and environmental controls. The nonurban HCC will continue to cultivate and maintain these relationships and provide training and education to members as appropriate.

Non-Pharmaceutical Interventions

Non-Pharmaceutical interventions, or NPIs, will center primarily around coordinated communication within all HCC partners. Established educational materials from the CDC will be used initially. Personal, community and environmental NPIs will be preidentified and education as to their effectiveness communicated to HCC partners. PIOs will be cultivated to provide leadership and support appropriate sourcing of needed materials specific to the occurrence.

Surge Staffing

While mutual aid is a key component to addressing surge staffing needs, each member entity is encouraged to develop policies and procedures around the rapid onboarding of additional staff members and volunteers.   Healthcare Facility Onboarding Checklist Strategies for Managing a Surge in Healthcare Provider Demand

Mutual Aid

The HCC does not direct or execute mutual aid activities; however, coalition members are encouraged to participate in mutual aid systems within their respective discipline to facilitate agreements to share staff and resources.

Hospital

Facilitated by: MHA
Mutual Aid Agreement

Facilitated by: MOSCOPE
Under development

Facilitated by: MOSCOPE
Mutual Aid Plan

Contingency Strategies	Crisis Strategies
Adjusting staff schedules, hiring additional HCP, and rotating HCP to positions that support patient care activities. **Developing regional plans to identify designated healthcare facilities or alternate care sites with adequate staffing to care for patients with infection.** **Allowing asymptomatic HCP who have had a higher-risk exposure to the infectious disease but are not known to be infected to shorten their duration of work restriction as directed**.	**Implement regional plans to transfer patients with the infectious disease to designated healthcare facilities, or alternate care sites with adequate staffing** **Allow asymptomatic HCP who are not fully vaccinated and have had a higher-risk exposure to but are not known to be infected to continue to work onsite throughout their post-exposure period.** **If shortages continue despite other mitigation strategies, as a last resort consider allowing HCP with suspected or confirmed infection who are well enough and willing to work but have not met all "Return to Work Criteria" to work.**

Supply Chain, Supplies, Personal Protective Equipment (PPE)
Supply chain awareness and PPE supply needs can be communicated and filled within the HCC if the resources are available. General guidance to address shortages including crisis Standards of care will be communicated and status shared among HCC partners.

Nonurban HPP Assets
MHA facilities the coordination of assets in the nonurban regions of Missouri. Each are owned and maintained by a participating hospital in the health care coalition. Current asset status, inventory and contact information is available on the Mobile Medical Asset view of EMResource®. To request an asset, use the contact information in EMResource or contact MHA staff for assistance. In addition to all ESF 8 assets the Nonurban HPP assets include:

Communication Trailers (16)
The catastrophic deployment plan for these assets is under development. Each communication asset maintains the following capabilities:
- satellite connectivity for Internet and phone communication
- VHF/UHF radio

- radio scanner
- wireless Internet
- voice over Internet protocol
- radio over internet protocol/PCNXU software
- amateur radio (optional)
- MOSWIN
- 8 trailers also have MCI supplies which include medical supplies and equipment to support mass casualty incident response (see Annex B for inventory)
- 8 trailers are command trailers

Medical Surge Caches

These caches include durable medical equipment needed to support an expected patient surge. The caches are stored in either 250-bed or 500-bed capacity for a total of 5,500 beds in the nonurban regions of Missouri (see Annex B for inventory).

Respiratory Cache (1)

The respiratory cache has the ability to generate oxygen, fill oxygen tanks, and support ventilators and cannulas (see Annex B for inventory).

Mortuary Cache *(9)*

The mortuary caches are temporary morgue units with the capacity to hold 8 decedents using a cooling system. They can be used in hospital surge or local/community fatality surge situations. These caches are portable and can be fully operational in less than 15 minutes upon arrival on site.

Highly Infectious Disease Cache *(8)*

The HID caches include ISOPOD units that can be used for the isolation, treatment and transport of patients with a highly infectious disease.

Support Services
Laboratory

NUMO HCC members rely on a variety of modalities for initials detection of pathogens or biological threats. These include Fire and EMS Hazardous material responses and initial testing of substances in the field, frontline healthcare facilities, Sentinel laboratories, State Laboratory Response Network and the CDC reference labs. The NUMO will work to communicate with all partners should a biological terrorism agent be found or an outbreak of infectious disease. In addition, for diseases that are Highly infectious the Region that is impacted will be notified to coordinate and support the transport and response among healthcare partners. Key components will be information sharing and situational awareness.

	EMS / HAZMAT Teams	First Receivers	Sentinel Laboratories
Anthrax	Surface sampling procedures for *Bacillus anthracis* spores	Collecting and Preparing Specimens for Anthrax Testing Packaging and Shipping Specimens for Anthrax Testing	Clinical Laboratory Guidelines: Anthrax
Botulinum Toxin		Submit a Specimen to CDC for Testing Suspected Cases of Botulism	Clinical Laboratory Guidelines: Botulinum Toxin
Brucellosis (Bacteria)	EMS Brief Brucellosis	Brucellosis Reference Guide	Sentinel Laboratory Guidelines For Suspected Agents Of Bioterrorism - Brucella species
Plague: Pneumonic (Bacteria)	NRT Quick Reference Guide: Yersinia pestis (Causes the disease Plague)	CDC resources for Clinicians on Pneumonic plague	Sentinel Level Clinical Laboratory Guidelines For Suspected Agents Of Bioterrorism – Y Pestis
Q-Fever	National Response Team – Quick Reference Guide Q-fever	CDC Q-fever case report form CDC Q-fever Laboratory Confirmation Diagnosis of Acute Q fever	Sentinel Level Clinical Laboratory Guidelines For Suspected Agents Of Bioterrorism – Q Fever
Ricin (Biotoxin)	National Response Team – Quick Reference Guide Ricin	Laboratory Testing for Ricin Guidance CDC	Sentinel Labs are not typically used for chemical / environmental testing.

		Laboratory Information for Chemical Emergencies	
Smallpox (Virus)	NRT Quick Reference Guide: Smallpox (Variola major, Variola minor	Acute, Generalized Vesicular or Pustular Rash Illness Testing Protocol in the United States Specimen Collection and Transport Guidelines for Suspect Smallpox Cases	Sentinel Level Clinical Laboratory Guidelines For Suspected Agents Of Bioterrorism – small pox
Staphylococcal Enterotoxin B (Toxin)			Sentinel Level Clinical Laboratory Guidelines For Suspected Agents Of Bioterrorism – Staphylococcal Enterotoxin B
Tularemia (Bacteria)	NRT Quick Reference Guide: Francisella tularensis (Causes the disease Tularemia)	Tularemia Laboratory Diagnosis	Sentinel Level Clinical Laboratory Guidelines For Suspected Agents Of Bioterrorism – tularemia
Viral Hemorrhagic Fevers (Virus)	NRT Quick Reference Guide: Hemorrhagic Fever (HF) Viruses	Guidance for Collection, Transport and Submission of Specimens for Ebola Virus Testing	Sentinel Level Clinical Laboratory Guidelines For Suspected Agents Of Bioterrorism – tularemia

Waste Management, Decontamination

Both federal and state regulations address the safe transport and storage of on- and off-site regulated medical wastes. Health-care facilities are instructed to dispose medical wastes regularly to avoid accumulation. Medical wastes requiring storage should be kept in labeled, leak-proof, puncture-resistant containers under conditions that minimize or prevent foul odors. The storage area should be well ventilated and be inaccessible to pests. Any facility that generates regulated medical wastes will act within their established policies and protocols for their facilities regulated medical waste management plan to ensure health and environmental safety as per federal, state, and local regulations. In addition, regulated medical waste will be deposed of in a manner consistent with CDC Infectious Disease Guidance and OSHA guidelines that may be organism or disease specific.

Patient Care/Management

Patient care will be local control. The Healthcare coalition does not provide medical control, but will openly share best practices, clinical updates and work to coordinate any needed support as requested by coalition members.

Medical Countermeasures

	LETHALITY	VACCINE	TREATMENT	RESOURCES
Anthrax (inhalation)	High	Licensed	Antibiotics	Anthrax Vaccination: Information for Health Professionals
Plague (Yersinia pestis)	High unless treated within For up to 1 year in soil; Not current Antibiotics 12–24 hours (pneumonic)	Not Current NIH Plague Vaccine: recent progress and prospects 2019	Antibiotics Early treatment and prophylaxis with streptomycin or gentamicin or the tetracycline or fluoroquinolone classes of antimicrobials would be advised.	CDC Plague Landing Page NIH Plague as a Bioweapon CDC Recommended Antibiotic Treatment for Plague
Tularemia (Francisella tularensis)	Moderate	Not current – under development	Antibiotics	CDC Consensus Statement: Tularemia as a Biological Weapon: Medical and Public Health Management
Marburg (Viral hemorrhagic fever)	>25% lethal	No	Supportive treatment only	
Ebola (Viral hemorrhagic fever)	50–80% lethal	Licensed Ervebo	Supportive Treatment	FDA Ebola Preparedness CDC Ebola Virus Disease for Clinicians NETEC

Smallpox (Variola major virus)	High to moderate Very stable Licensed Supportive ≥30% lethal	Licensed		Smallpox Vaccination: Information for Healthcare Providers
Botulism (Clostridium botulinum toxin)	High without Stable for weeks in Licensed Antitoxin if respiratory support	Licensed (availability uncertain)	Antitoxin if administered quickly respiratory support	BAT (Botulism Antitoxin Heptavalent) BabyBIG (Infant botulism antitoxin) Video how to mix and administer botulism antitoxin
Q fever (Coxiella burnetii)	Very low	Not licensed in U.S.	Antibiotics	
Ricin (Ricinus communis)	High (injected)	Investigational	No antidote	DHSS Response to a Ricin Incident LPH and Medical Officials
Respiratory Viruses (Panflu,				

Community-based Testing

Community-based testing can be supported through the HCC. Situational awareness, best practices should be shared as a part of the coalition briefing schedule. A recommended practice is to identify community-based testing sites on the regional eICS incident and update statuses as they are known in a routine cadence. Community testing will be led by the state health lab and DHSS as appropriate for the organism and outbreak. HCC are encouraged to facilitate and support testing as they have capacity, training and expertise. A coalition best practice would be to create Just in Time Training templates for testing procedures specific to common venues and modalities in the region.

Patient Transport

EMS strike teams are available within the NUMO HCC. Strike teams for all incidents are requested by the primary EMS agency at the scene of the incident who is requesting support. The request is made to the regional EMS Mutual Aid Coordinator who then rosters a strike team and reports the team status in EMResource and in a separate eICS incident for situational awareness. The NUMO HCC should monitor and support EMS strike teams as they are able.
Highly Infectious Disease EMS teams with appropriate PPE and training have been identified to cover each region of the NUMO HCC.   These EMS providers have been identified and operate based upon the Ebola Response Plan and are pediatric capable.

Mass Fatality

The Nonurban Missouri HCC maintains fatality caches. All regions of the state have Regional Mass fatality plans that HCC members should be advised of. Regional HCC should have awareness of their regional mass fatality plan and consider how to best incorporate this response capability into the

HCC. HCC leadership will work to understand and incorporate awareness of the Missouri State plan and Victim Information Center Plan as it relates to mass fatality and biological terrorism.

Special Considerations
Behavioral Health
Behavioral Health facilities and resources are a component of the nonurban HCC and support situational awareness and are an integral component of best practice and information sharing resources.

At-Risk Populations
The HCC has access to resources to assist with response in respect to special populations. The state of Missouri has developed maps using federal data. The first map, emPOWER, includes information on Medicare beneficiaries that rely on electricity-dependent medical equipment to live in their homes. The second map includes information from CDC's Social Vulnerability Index (SVI). This data uses 15 U.S. census variables to help local officials identify communities that may need additional support during a response.

Situational Awareness

Communications
The primary communication method for the nonurban Missouri health care coalition is Juvare's EMResource and eICS platforms and the secondary communication is MOSWIN radios. However, there are numerous modes of communication available to anyone at any time. During emergency situations, communication systems may become overloaded because of an increased need for messaging, and a system failure can occur as a result.

All coalition members have access to and have shared the necessary landline telephone, cellular telephone and email contact information for inclusion on the coalition contact information roster. Following are the various modes of communication available to the Healthcare Coalition.

EMResource®
- EMResource® is a Web-based data management tool that is available to all healthcare organizations in Missouri. The tool is used for daily bed management, as well as for emergency preparedness and response. The regular use of the system helps ensure accurate and timely information sharing during unplanned events.
- EMResource® lists each healthcare organization as an individual resource, as well as each healthcare coalition and metropolitan coordinating entity.
- EMResource® users can request, in advance, automated notifications from the application when statuses change or when events occur.
- Hospitals can alert "followers" when their diversion or incident command activation status changes.
- Local public health agencies and federally qualified health centers can adjust their operational status, triggering a notification to those registered to receive the information.
- Furthermore, healthcare coalitions can alert members of changes in their activation status, whether providing an advisory, an alert, or activating the coalition.
- EMResource is accessible on cellular devices through the EMResource mobile application.

eICS®
Web-based application for incident management available to hospitals and healthcare coalitions. The application provides the following features:
- contact list and automated notification
- library for plans, standard operating guidelines and preparedness documentation
- incident response guides that facilitate an appropriate response based on pre-established
- response objectives and key action items
- post-event documentation and report generation
- eICS is accessible on cellular devices.

MOSWIN - Missouri Statewide Interoperability Radio Network
MOSWIN radios have been installed in 52 hospitals and 88 Public Health Agencies. There is a standard programming list for all hospitals and LPHAs respectfully. There are talkgroups within both lists that gives hospitals, LPHAs and MHA ability to communicate. The Mobile Medical Assets are programmed with talkgroups for all regions.
- First Option: MHA1
- Second Option: MHA2

Hospital Emergency Administrative Radio (HEAR)
All acute care hospitals with emergency departments are able to monitor HEAR 155.340 with a dedicated receiver/base station to communicate with surrounding hospitals (approx. 30 mile range) and incoming ambulances, as well as possible EMS commander at on-scene triage areas.

VHF and 800 MHz Radio
All hospital command staff should have access to their local agencies and first responders via local radio systems. If VHF is not the system used by local agencies, hospital-specific emergency preparedness plans should include access to local agencies and any related mutual aid talk groups.

Amateur Radio
Healthcare coalition members should use amateur radio as a backup communications service, specifically for point-to-point communications.

Jurisdictional-Specific Considerations
This plan is intended to support, not replace, existing facility and jurisdictional plans. Healthcare entities and jurisdictions should maintain and develop their emergency management programs.

Training and Exercise
This plan will be widely disseminated and incorporated into future trainings and offerings. Components of the annex will be woven into future exercises in an effort to diversify response options.

Deactivation and Recovery

When the need for coalition response has ended, all coalition members should be notified that the incident has ended through EMResource and eICS, or through another appropriate communication channel. If a coalition activated, the HCC may choose to move to an advisory or alert before completely ending the event as there may be a need for additional monitoring. The HCC should conduct an After Action Process and should revise any necessary plans.

As the healthcare coalition starts planning for termination and demobilization of coordination personnel and assets, a detailed assessment of communications needs, resources and limitations should be performed by a coalition member. These recommendations should be included in the incident command objectives, and timelines for demobilization of MHA resources and mutual aid personnel should be maintained or released consistent with the best support for the incident.

EMS BIOTERRORISM GUIDE

DISEASE AND METHOD OF INFECTION:	SIGNS & SYMPTOMS	TRANSMISSION AND PRECAUTIONS	PATIENT TREATMENT AND TRANSPORT	CLEANING & DISINFECTION OF EQUIPMENT, LINEN AND SURFACES
Anthrax: Inhalation (Bacteria) Method of Infection: Inhalation. Incubation Period: 1 –7 days of exposure Up to 42 days to appear.	Mild, non-specific respiratory illnesses. Sore throat, fever, dyspnea, cough, mild chest discomfort, respiratory distress, fatigue, muscle aches and discomfort, abdominal pain, skin lesions. Possible short recovery phase then onset of dyspnea, respiratory failure, confusion, diaphoresis, stridor, cyanosis, shock.	Transmission: No person-to-person transmission. Personal Protection Equipment & Precautions: • Gloves • Respiratory mask N95 or greater. • Eye protection/face shield. • Proper hand washing. STANDARD PRECAUTIONS	Do not perform mouth-to-mouth respirations. Supportive therapy. Statewide and Regional EMS Treatment and Transport Protocols.	Routine linen management. Decontaminate surface with 10% hypochloritic solution. After each patient, disinfect patient care equipment.
Botulinum Toxin Method of Infection: Inhalation; food ingestion. Incubation Period: 2 hours to 3 days Onset of symptoms commonly between 12- 36 hours.	Fever, vomiting, diarrhea, dry mouth, dilated or unreactive pupils, drooping eyelids, weakened jaw, difficulty swallowing or speaking, double vision, slurred speech, generalized weakness, dizziness, descending flaccid paralysis and respiratory distress/	Transmission: No person-to-person transmission. Personal Protection Equipment & Precautions: • Gloves • Eye protection/face shield if potential for splashing.	Do not perform mouth-to-mouth respirations. No transport restrictions. Urgent transport to prevent respiratory failure.	Routine linen management. Decontaminate surfaces with 10% hypochloritic solution. After each patient, disinfect patient care equipment.

	failure, intact mental state. Gastrointestinal symptoms accompany foodborne botulism. Inhalation botulism does not present with GI symptoms.	• Proper hand washing. • N95 respirators or greater until verification that no aerosol delivery occurred. STANDARD PRECAUTIONS	If aerosol dispersed, patient decon with soap and water. Supportive therapy; respiratory support. Statewide and Regional EMS Treatment and Transport Protocols.	
Brucellosis (Bacteria) Method of Infection: Contaminated food Ingestion Incubation Period: 5 days – 2 months	Fever (often intermittent) headache, chills, heavy sweating, joint pain. Most common findings are lymph node disease and enlargement of the spleen. Systemic illness may become chronic with fever and weight loss. May have pus-foaming lesions. Bone/joint pain common.	Transmission: Person-to-person transmission is rare. Ingestion Personal Protection Equipment & Precautions: • Gloves • Respiratory maskN95 or greater. • Proper hand washing. AIRBORNE PRECAUTIONS	No transport restrictions. Supportive therapy. Statewide and Regional EMS Treatment and Transport Protocols.	Routine linen management. Decontaminate surfaces with 10% bleach solution. Do not use bleach on patient. After each patient, disinfect patient care equipment.
Plague: Pneumonic (Bacteria) Method of Infection: Inhalation Incubation Period: 1 – 6 days	Sudden onset of high fever, chest pain, cough chills, headache, muscle pain, vomiting. Weakness/prostration, swollen lymph nodes. Dyspnea, stridor, cyanosis.	Transmission: Person-to-person transmission via respiratory inhalation and infected flea bites. Personal Protection	Do not perform mouth-to-mouth respirations. Place N95 respiratory mask on patient.	Routine linen management. Decontaminate surface with 10% bleach solution. Do not use bleach on patient.

	Gastrointestinal symptoms. Sputum initially watery, then bloody, rapidly developing pneumonia, cyanosis, shock, rapid death.	Equipment & Precautions: • Gloves • Respiratory mask N95 or greater • Eye protection/face shield. • Disposable full-length gown or jumpsuit. • Disposable shoe covers. • Proper hand washing. DROPLET PRECAUTIONS	Limit movement as much as possible.	After each patient, disinfect patient care equipment.
Q-Fever Method of Infection: Inhalation and ingestion. Incubation Period: 2 – 3 weeks	High fever, chills, severe headache, pain in the eye cavity, pain the chest cavity, cough, heavy sweating, pleuritic chest pain. Weight loss, muscle and joint pain, diarrhea, neck stiffness, bodily discomfort/fatigue.	Transmission: Person-to-person transmission is rare. Personal Protection Equipment & Precautions: • Gloves • Respiratory mask N95 or greater. • Eye protection/face shield. • Proper hand washing.	Do not perform mouth-to-mouth respirations. No transport restrictions	Soap and water or a 0.5% chlorine solution. Routine linen management. After each patient, disinfect patient care equipment.
Ricin (Biotoxin) Method of Infection: Inhalation, ingestion and injection. Signs/symptoms occur 18-24 hours after	Inhalation: Chest tightness, weakness, fever, progressive cough, pulmonary edema, cyanosis, dyspnea, nausea and joint pain. Allergic/asthma like symptoms: congestion of nose/throat,	Transmission: No person-to-person transmission. Personal Protection Equipment & Precautions: • Gloves	Do not perform mouth-to-mouth respirations No other transport restrictions Airway, Breathing and Circulation.	Routine linen management. Hypochlorite solution 10% sodium hypochlorite. After each patient, disinfect patient care

inhalation exposure; followed by severe respiratory distress and death from hypoxemia in 36-72 hours.	itchiness of eyes, hives. Respiratory distress and death. Ingestion and Injection: Internal bleeding, vomiting and bloody diarrhea. Hallucinations, seizures, low blood pressure.	• Respiratory mask N95 or greater. • Goggles with respiratory protection or full face-piece respirator • Proper hand washing. SPECIAL RESPIRATORY PRECAITIONS	100% oxygen via nonrebreather. Statewide and Regional EMS Treatment and Transport Protocols.	equipment. Use dry clean up procedures (e.g., hepa vacuum).
Smallpox (Virus) Method of Infection: Inhalation of droplets Contact with shedding virus. Direct contact of infected bodily fluids or contaminated objects. Incubation Period: A. Range from 7 – 17 days Not contagious during this phase. B. First on-set of symptoms, sometimes contagious. symptoms last approximately 2-4 days. C. Rash emerges- most	Disease On Set: acute onset of discomfort, extreme exhaustion, severe abdominal pain, fever, chills, cough, vomiting, muscle tremors, headache and backache. Eruptive Disease or Fever: appears as soon as 2-3 days. Discrete maculo-papular rash on face, hands, forearm, mouth and pharynx. Palm and soles is common. Rash spreads to legs and then centrally to trunk (Week 2)	Transmission: Person-to-person. Personal Protection Equipment & Precautions: • Gloves • If rash present, respiratory mask N95 or greater. • Disposable full-length gown or jumpsuit of Tyvek or equivalent material. • Disposable shoe covers/head cover • Proper hand washing. • Eye/splash protection if performing procedures that may cause splash. SPECIAL RESPIRATORY PRECAUTIONS	Do not perform mouth-to-mouth respirations. Use disposable linens. Place sheet or blanket over patient completely covering body from neck to feet. Place surgical mask on patient, if not administering oxygen via non-rebreather mask.	Clean floors using a single bucket procedure of wet mopping using solution. • The contents of the bucket should be emptied into the toilet. • Disposable mop head and cleaning cloths should be used. • Mop head should be removed and disposed of by placing in red lined trash bag. • Bag linen and place in a second red bag. • Autoclave non-disposable linen before transporting to laundry. • Autoclave waste before

contagious. Person remains contagious until all of the scabs have fallen off.				incinerating. • Decontaminate surface with 10% bleach solution. Do not use bleach on patient. • After each patient, disinfect patient care equipment.
Staphylococcal Enterotoxin B (Toxin) Method of Infection: Inhalation	Fever, chills, muscle pain, nausea, diarrhea and cough; Shortness of breath, chest pain.	Transmission: No person-to person transmission. Personal Protection Equipment & Precautions: • Gloves • N95 respiratory mask (or greater). • Proper hand washing.	Do not perform mouth-to-mouth respirations. Supportive therapy. Statewide and Regional EMS Treatment and Transport Protocols. Patient decon: soap and water.	Decontaminate surfaces with 10% bleach solution. Do not use bleach on patient. After each patient, disinfect patient care equipment.
Tricothecene Mycotoxins (T-2) (Toxin) Method of Infection: Inhalation	Skin – burning pain, redness, tenderness, blistering. Nasal itching and pain, sneezing, nosebleeds. Dyspnea, wheezing and cough. Chest pain, blood stained sputum. Eyes – pain, tearing, redness, foreign body sensation and blurred vision.	Transmission: No person-to person transmission. Personal Protection Equipment & Precautions: • Gloves • Respiratory mask N95or greater • Eye protection/face shield. • Disposable full-length gown	Do not perform mouth-to-mouth respirations. Remove patients outer clothing. Decontaminate exposed skin with soap and water. Eye exposure: copious saline irrigation.	Decontaminate surfaces with hypochlorite solution under alkaline conditions such as 1% sodium hypochlorite and 0.1 bleach. After each patient, disinfect patient care equipment.

			or jumpsuit of Tyvek or equivalent material. • Disposable shoe covers. • Proper hand washing.	Superactive charcoal if toxin has been ingested.	
Tularemia (Bacteria) Method of Infection: Inhalation. Incubation Period: 3 to 5 days	Fever, chills, headache, discomfort, chest discomfort, anorexia, cough. Sore throat, shortness of breath, diarrhea, muscle pain, vomiting. Hemorrhage, weakness/ prostration, abdominal pain, swollen lymph nodes. Pneumonia in 30-80% of patients. Diffuse, varied skin rash. May be rapidly fatal.	Transmission: No person-to-person transmission. Personal Protection Equipment & Precautions: • Gloves • Respiratory mask N95 or greater. • Eye protection/face shield • Disposable full-length gown or jumpsuit of Tyvek or equivalent material. • Disposable shoe covers. • Proper hand washing.	Do not perform mouth-to-mouth respirations. No other transport restrictions	Routine linen management. Decontaminate surfaces with 10% bleach solution. Do not use bleach on patient. After each patient, disinfect patient care equipment.
Viral Hemorrhagic Fevers (Virus) Arenavirus Ebola Filoviruses Method of Infection: Direct contact and inhalation.	Fever, muscle pain, easy bleeding, red itchy eyes, vomiting, bleeding, hypotension, headache, and shock. Delirium, seizures and coma. Diarrhea, flaccid paralysis, weakness.	Transmission: Person-to-person transmission. Personal Protection Equipment & Precautions: • Gloves • Respiratory mask (N95or greater).	Do not perform mouth-to-mouth respirations. Supportive therapy. Statewide and Regional Treatment and Transport Protocols.	Routine linen management. Decontaminate surfaces with 10% bleach solution, hypochlorite or phenolic disinfectants. After each patient, disinfect

		• Eye protection/face shield • Disposable full-length gown or jumpsuit. • Proper hand washing. HIGHLY INFECTOUS DISEASE		patient care equipment.

Districts for Statewide Disease Investigation/Terrorism Response/TB Control

Districts for Statewide Disease Investigation / Terrorism Response / TB Control
Missouri Department of Health and Senior Services
Division of Community and Public Health
Bureau of Communicable Disease Control and Prevention
930 Wildwood, Jefferson City, MO 65109

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State Epidemiologist
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(573) 526-0235 FAX

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Joplin, MO 64801
(417) 629-3487
(417) 629-3477 FAX
Regions: A, D, E, G, and H

Bev Myers, RN
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Park Hills, MO 63601
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Regions: B, C, F, and I

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May 2021

Map districts: NORTHWEST (A), CENTRAL (F), EASTERN (C), SOUTHWEST (D), SOUTHEAST (G), H, B, E, I
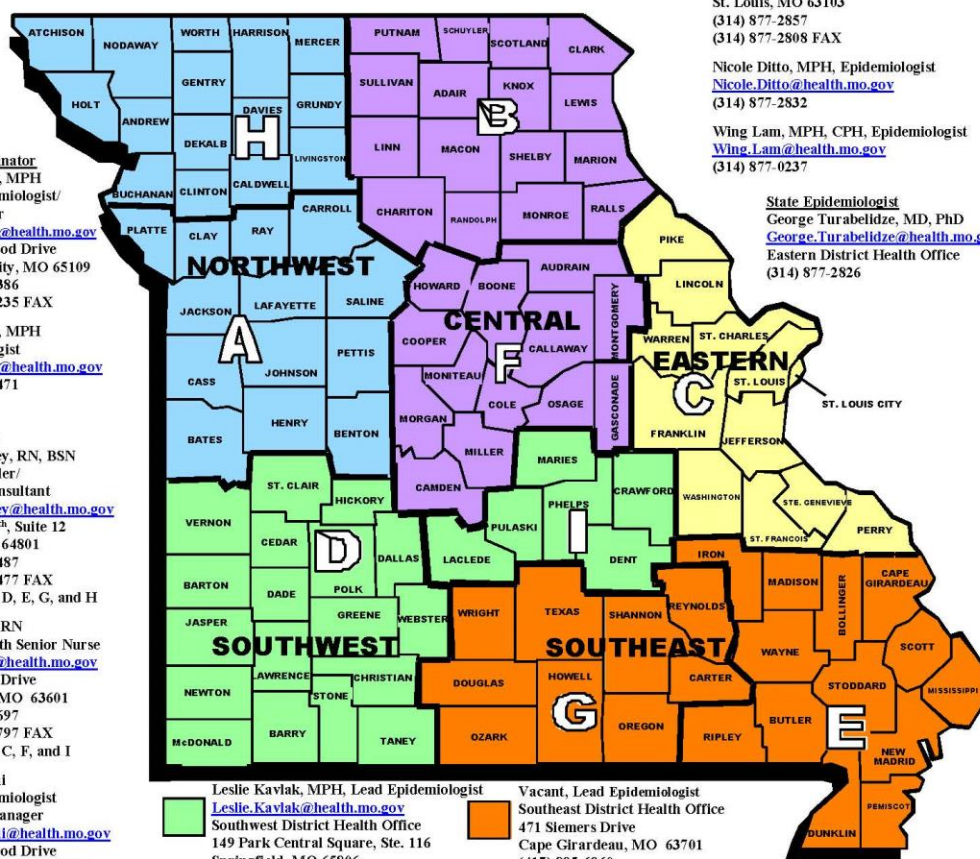
Regional Hazmat Teams List from SEMA

Missouri Hazardous Materials Teams
Hazmat Contact List November 3, 2020

Region A – All Type II with most capabilities of Type I
Kansas City Fire Department HazMat
Pete Knudsen 816-513-4674 (office) peter.knudsen@kcmo.org
6000 Truman Road 816-799-7609 (cell)
Kansas City, MO 64126 816-784-9230 (fax)
KCFD Dispatch 816-513-0900
HazMat Chief 816-241-1004 (fax)
Whiteman AFB FD HazMat
Dispatch 660-687-4507
SMSgt Mike Champion 509 CES/CEF
MSgt Justin Pederson 509 CES/CEF
MSgt Joe Charleston 509 CES/CEF
Darren Millard 509 CES/CEF
660 10th St. Suite 211
Whiteman AFB, MO 65305-5074 660-687-3739 (fax)

Missouri Hazardous Materials Teams
Hazmat Contact List November 3, 2020
Lee's Summit Fire Department HazMat – Type II
Chief Mike Snider 816-969-1302 mike.snider@cityofls.net
Lee's Summit Fire 816-969-1313 (Admin fax)
207 S.E. Douglas St. 816-969-1300 Administrative Offices
Lee's Summit, MO 64063 816-969-7360 (dispatch)
Asst. Chief Dan Manley 816-969-1304 dan.manley@cityofls.net
816-935-3456 (work cell)
816-588-6806 (personal cell)
Lee's Summit Emergency Comms 816-969-7407 (requests for response)
816-969-1374 (Comm Center Fax)
Independence Fire Department- Type II
Chief Douglas Short 816-325-7164 dshort@indepmo.org
950 N. Spring Street 816-365-7466 (cell)
Independence, MO 64050 816-325-7130 (fax)
Deputy Chief Mark Carrick 816-325-7165 mcarrick@indepmo.org
816-365-7466
Bat. Chief Craig Duplantis 816-325-7161 cduplantis@indepmo.org
816-365-3909 (cell)
Tri-District – Central Jackson, Ft. Osage, Sni Valley HazMat-Type II
Asst. Chief Jason Bonney 816-797-9199 (cell) jbonney@cjcfpd.org
Central Jackson Co. FPD 816-463-8541 (office-direct)
816-229-2522 (office)
4715 W US 40 Hwy 816-229-2152 (fax)
Blue Springs, MO 64015 816-220-4005 (PSAP dispatch)

816-923-7453 (KCFD dispatch)
Deputy Chief Kirk Lair 816-797-9193 (cell) klair@cjcfpd.org
Central Jackson Co. FPD 816-229-5110 (fax)

Missouri Hazardous Materials Teams

Hazmat Contact List November 3, 2020

Region B

Kirksville/Adair County HazMat- Type III
Jon Cook, Fire Chief 660-6653734 (Office) jcook@kirksvillecity.com
Kirksville Fire 660-342-8340 (Cell)
401 N. Franklin 660-627-7011 (fax)
Kirksville, MO 63501

Hannibal Fire HazMat Team- Type II
Dispatch: 573-221-1244
Deputy Chief Ryan Neisen 573-221-0657 (work) rneisen@hannibalfire.com
2333 Palmyra Road 573-231-5078 (cell)
Hannibal, MO 63401
573-221-2431 (fax)
Shawn Smith, HazMat Officer 573-221-4340 (Station 1) ssmith@hannibalfire.com
Hannibal Fire Station 1 217-430-3995 (cell)
205 South 4th St. 573-221-0657 (Administration Office)
Hannibal, MO 63401
Chief Mike Benjamin 573-221-0657 (work)
2333 Palmyra Road 573-822-2515 (cell)
Hannibal, MO 63401

Missouri Hazardous Materials Teams

Hazmat Contact List November 3, 2020

Region C – all teams Type II

St. Charles-Warren-Lincoln County Hazardous Materials Response Team – Type II
Brian Gettemeir 636-447-6655 (office) bgettemeier@cottlevillefpd.org
Cottleville Fire Department 314-330-7074 (cell) BGettemeier@gmail.com
1385 Motherhead Road 636-441-1742 (fax)
St. Charles, MO 63304 636-332-8744 (dispatch)

Special Operations Team of St. Louis County - Type II with Type I capabilities
Andy Seers, Deputy Chief 314-432-5570 (office)
Creve Coeur Fire District 314-393-4146 (cell)
11221 Olive Blvd. 314-432-2367 (fax)
Creve Coeur MO, 63011
Email: aseers@ccfire.org
Mike Digman, Battalion Chief 6360458-2100 (office)
MetroWest Fire District 636-262-3305 (cell)
Email: mikedig@metrowest-fire.org

St. Louis City Fire Department HazMat- Type II
Chief Dennis Jenkerson 314-289-1953 (work) jenkersond@stlouis-mo.gov
1421 N. Jefferson 314-481-3679 (home)
St. Louis, MO 63106 314-807-4860 (cell)
Mike Arras 314-289-1971 (work) arrasm@stlouis-mo.gov
Deputy Chief, Special Operations 314-807-4902 (cell)

Missouri Hazardous Materials Teams

Franklin County HazMat – Type II

EMD Mark Skornia 636-221-4672 (cell) mskornia@washmo.gov

636-231-4101 (office)

Deputy Chief Mike Holtmeier 636-432-4439 (cell) mholtmeier@washmo.gov

Washington Fire Department

200 E. 14th Street 636-390-1020 (office)

Washington, MO 63090 636-390-1026 (fax)

Washington Communications 636-390-1050 (24 hour contact)

Missouri Hazardous Materials Teams

Region D

Springfield Fire\Logan-Rogersville Department HazMat-Type II

911 Dispatch 417-864-1708

David Pennington, Fire Chief 417-874-2310 (office) dpenning@springfieldmo.gov

830 Boonville Avenue 417-839-2437 (cell)

Springfield, MO 65802 417-874-2300 (work)

Chief Richard Stirts 417-753-4265 rstirts@lrfire.org

Logan-Rogersville FPD 417-753-4340 (fax)

3427 S. State Hwy 125 417-839-5697 (cell)

Rogersville, MO 65472

Joplin Fire Department HazMat – Type II

Chief Jimmy Furgerson 417-624-0820 ext 1300 jfurgers@joplinmo.org

303 E. 3rd Street 417-439-0789 (cell)

Joplin, MO 64802 417-625-4709 (fax)

Andy Nimmo 417-624-0820 ext 1301 animmo@joplinmo.org

Deputy Chief 417-437-6983 (cell)

417-625-4709 (fax)

Western Taney County HazMat-Type II

Chief Chris Berndt 417-334-3440 (office) chris.berndt@westerntaneyfire.com

221 Jefferson Rd 417-335-0586 (cell)

Branson, MO 65616 417-546-7250 (dispatch)

417-334-3446 (fax)

Missouri Hazardous Materials Teams

Region E

Region E HRST- Type II

Lt. Derick Wheetley 573-471-6200 (work) dwheetley@sikeston.org

Sikeston DPS 573-471-4711 (24 hr dispatch)

201 S. Kingshighway 573-275-1743 (cell)

Sikeston, MO 63801

Sean Mitchel 573-587-0159 (24 Hour) smitchell@jacksonfire.org

Jackson Fire

503 South Hope

Jackson MO, 63755

Brad Dillow

573-270-2625

Kennett Fire Department HazMat – Type II

Paul Spain, Fire Chief
Personal Info.
804 Michael St
Kennett MO 63857
Personal Cell Phone: 573-344-1716
Personal Email: kfd111@yahoo.com
Work Info.
200 Cedar St.
Kennett MO 63857
Work Cell Phone: 573-717-6442

Missouri Hazardous Materials Teams
Hazmat Contact List November 3, 2020
Work Email: kfdcheif@kennettfd.org
Work Landline Phone: 573-888-5337
Lance Davis, Assistant Fire Chief
Personal Info. 2804 State Hwy Y
Kennett, MO 63857
Personal Cell Phone: 573-344-3748
Personal Email: kc0ufp@yahoo.com
Work Info.
200 Cedar St.
Kennett MO 63857
Work Phone: 573-717-6442
Work Email: kfdac@kennettfd.org
Work Landline Phone: 573-888-5337

Ozark Regional Homeland Security Team
Bob Fredwell 573-718-3244 bfredwell@imsinternet.net
Poplar Bluff, MO
Jackson Bostic 573-429-5278 jbostic@semo.net
Poplar Bluff, MO

Missouri Hazardous Materials Teams
Hazmat Contact List November 3, 2020

Region F
Columbia Fire Department HazMat – Type II
Fire Chief Andy Woody 573-817-5038 (office) andy.woody@como.gov
Columbia Fire Department 573-874-7446 (fax)
201 Orr Street 573- 447-9132 (cell)
Columbia, MO 65201
To request mutual aid: Columbia Public Safety Joint Communication 573-874-7470
Cole County Emergency Response Team – Type II
Chief Bill Farr 573-619.9914 (cell) bfarr@colecounty.org
1736 Southridge Drive 573-634-9164 (office)
Jefferson City, MO 65109
Deputy Chief Shawn York 573-690-5117 (cell) shawn@midmoenviro.com
Cole County
Deputy Chief Barry Gipe 573-291-7981 (cell) bgipe@colecounty.org
To call out the team, contact:
Joint Communications Cole Co. 573-634-6351/6400

Missouri Hazardous Materials Teams

Region G

West Plains Fire Department – Type II
Chief Roy Sims 417-256-2424 (office) roy.sims@westplains.gov
1901 Kissinger St. 417-280-6882 (cell)
West Plains, MO 65775
Asst. Chief Kurt Wilbanks 417-256-2424 (office) kurt.wilbanks@westplainsfd.org
417-255-3584 (cell)

Region H

Region H Haz-Mat Response Team - Type I
Bill Brinton 816-383-0604 (cell) bbrinton@co.buchanan.mo.us
Director/Chief 888-904-3914 (24 hour)
411 Jules St. Room 224 816-271-1574 (county phone)
St. Joseph MO 64501 816-901-1604 (Fax)

Missouri Hazardous Materials Teams

Region I

Rolla Fire & Rescue Regional HazMat – Type II
Ron Smith, Fire Chief 573-364-3989 (work) rsmith@rolacity.org
City of Rolla Fire & Rescue 573-308-1213 (911 Center)
1490 E 10th St. 573-578-2507 (cell)
Rolla, MO 6540 573-364-1224 (fax)
Jeff Breen, Assistant Fire Chief 573-364-3989 (work) jbreen@rollacity.org
573-202-4647 (cell)
573-308-1213 (911 Center)
Lebanon Fire Dept / Laclede County Hazardous Response Team – Type III – (LIMIT)
Chief Sam Schneider 417-532-2104 shschneider@lebanonmo.org
Lebanon Fire Dept.
370 N. Adams, PO Box 111 417-288-8317 (cell)
Lebanon, MO 65536 417-588-3377 (fax)

Missouri Hazardous Materials Teams

State of Missouri 24 Hr. Numbers

Division of Fire Safety (for statewide mutual aid activation):
Eric Hartman 573 821-0937 (cell)
573 751-1601 (office)
573 239-8854 (home)
eric.hartman@dps.mo.gov
Matt Luetkemeyer 573-301-5315 (cell)
573-751-1743 (office)
573-514-5284 (home)
matt.luetkemeyer@dfs.dps.mo.gov
MO National Guard, 7th CST – Type I
Commander (573) 659-1402 (work)
Lieutenant Colonel (573) 774-9800 (cell)
Christopher Ash christopher.m.ash.mil@mail.mil
Deputy Commander

MAJ Brian Hatcher (573) 659-1403 (work)
(573) 774-9798 (cell)
Missouri National Guard Joint Operations Center (573) 638-9803

Missouri Hazardous Materials Teams

Hazmat Contact List November 3, 2020

MO Department of Natural Resources
Environmental Emergency Response (EER)
24 hour Spill Line 573-634-2436
Brad Harris 573-644-3226
EER Section Chief 573-526-3380 (office)
MIAC 866-362-6422
SEMA 573-751-6422 or 866-362-6422 (24 hr)
573 526-9100 (main office #)
FBI
Kacie Laidacker 816-512-8747 (direct office)
WMD Coordinator 816-512-8747 (cell)
Kansas City Div. kllaidacker@fbi.gov
Dana Kreeger 816-512-8680 (direct office)
WMD Program Manager
Kansas City Div. 816-401-9512 (cell)
drkreeger@fbi.gov
Bill Dorsey 314-589-2616 (direct office)
WMD Coordinator 314-795-3045 cell
St. Louis Division 314-589-2500 (24 hour)
wjdorsey@fbi.gov
Todd Casey 573-636-1817 (direct office)
HERT Lead 573-418-2483 (cell)

Missouri Hazardous Materials Teams

Hazmat Contact List November 3, 2020