

MISSOURI HEALTHCARE COALITION

ESF8 Emergency Preparedness Alliance

Response Plan Infectious
Disease Annex

Updated June 2025

Revisions Table

Name	Title	Date	Summary of Changes
Kara Amann	Director of Hospital Preparedness Programs	January 2025	Updated to reflect HCC name change and incorporate mission and vision.
Keri Barclay	Manager of Clinical Preparedness	June 2025	Updated links

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Introduction

Missouri Healthcare 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.

Purpose

This plan provides the framework to guide the Missouri Healthcare 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 Missouri Healthcare 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 Missouri Health Care Coalition Response Plan will be managed and maintained by Missouri Hospital Association on behalf of the Missouri HCC. MHA will update this plan following an exercise or real-world event, or at least once annually with guidance from the 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

Planning Assumptions

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.

Just-in-time caches of PPE may be 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 opportunity.

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, will maintain procedures to quickly identify and isolate patients with possible infectious disease. This includes 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, will maintain procedures to quickly identify and isolate patients with possible infectious disease. This includes 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.

- For the MO HCC Barnes Jewish Hospital and the University of Kansas hospital system have self identified as potential Level 2 National Special Pathogen System, or NSPS, facilities to provide patient care and support. 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 will 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.
- Persons reported with nationally defined risk factors for High Consequence Infectious Disease, or HCID, ideally will be under active or direct active monitoring by a local public health agency (LPHA) which is routinely communicating a providing updates to DHSS.
- Persons with reported risk factors for HCID 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

Surveillance

Each region of the MO HCC should 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](#)

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.

Support Services

Laboratory

MO HCC members rely on a variety of modalities for initial 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 MO 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 Defense Health Agency Reference Sheet	Surface sampling procedures for <i>Bacillus anthracis</i> spores	Collecting Samples to Send to Laboratories (Anthrax) Submitting Specimens for Anthrax Testing	Clinical Laboratory Guidelines: Anthrax
Botulinum Toxin Defense Health Agency Reference Sheet	NRT Quick Reference Guide Botulism	CDC Clinical Overview of Botulism	Clinical Laboratory Guidelines: Botulinum Toxin
Brucellosis (Bacteria) Defense Health Agency Reference Sheet	NRT Quick Reference Guide Brucellosis	Brucellosis Reference Guide	Sentinel Laboratory Guidelines For Suspected Agents Of Bioterrorism - Brucella species
Plague: Pneumonic (Bacteria) Defense Health Agency Reference Sheet	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 Defense Health Agency Reference Sheet	National Response Team – Quick Reference Guide Q-fever	CDC Q-fever	Sentinel Level Clinical Laboratory Guidelines For Suspected Agents Of Bioterrorism – Q Fever
Ricin (Biotxin)	National Response Team – Quick Reference Guide Ricin	Laboratory Testing for Ricin Guidance CDC	Sentinel Labs are not typically used for chemical / environmental testing.

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		Laboratory Information for Chemical Emergencies	
Smallpox (Virus) Defense Health Agency Reference Sheet	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) Defense Health Agency Reference Sheet	NRT Quick Reference Guide: Francisella tularensis (Causes the disease Tularemia)	Tularemia Laboratory Diagnosis CDC Clinical Care of Tularemia	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 waste. Health-care facilities are instructed to dispose of medical waste regularly to avoid accumulation. Medical waste 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 waste 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 deposited 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	NETEC Resources for MVD

Ebola (Viral hemorrhagic fever)	50–80% lethal	Licensed Ervebo	Supportive Treatment	FDA Ebola Preparedness CDC Ebola Virus Disease for Clinicians NETEC
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Smallpox (Variola major virus)	High to moderate Very stable Licensed Supportive \geq 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 (Ricin 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 MO 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 MO 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 MO HCC. These EMS providers have been identified and operate based upon the Ebola Response Plan and are pediatric capable.

Mass Fatality

The 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.

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.

APPENDIX A: EMS Bioterrorism Guide

DISEASE AND METHOD OF INFECTION:	SIGNS & SYMPTOMS	TRANSMISSION AND PRECAUTIONS	PATIENT TREATMENT AND TRANSPORT	CLEANING & DISINFECTION OF EQUIPMENT, LINEN AND SURFACES
<p> Anthrax: Inhalation (Bacteria) Method of Infection: Inhalation. Incubation Period: 1 –7 days of exposure Up to 42 days to appear. </p>	<p> Mild, non-specific respiratory illness 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. </p>	<p> Transmission: No person-to-person transmission. Personal Protection Equipment & Precautions : • Gloves • Respiratory mask N95 or greater. • Eye protection/face shield. • Proper hand washing. </p> <p style="text-align: center; color: green;">STANDARD PRECAUTIONS</p>	<p> Do not perform mouth-to-mouth respirations. Supportive therapy. Statewide and Regional EMS Treatment and Transport Protocols. </p>	<p> Routine linen management. Decontaminate surface with 10% hypochloritic solution. After each patient, disinfect patient care equipment. </p>

<p>Botulinum Toxin</p> <p>Method of Infection: Inhalation; food ingestion.</p> <p>Incubation Period: 2 hours to 3 days</p> <p>Onset of symptoms commonly between 12- 36 hours.</p>	<p>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/</p>	<p>Transmission: No person-to-person transmission.</p> <p>Personal Protection Equipment & Precautions :</p> <ul style="list-style-type: none"> • Gloves • Eye protection/face shield if potential for splashing. 	<p>Do not perform mouth-to-mouth respirations.</p> <p>No transport restrictions.</p> <p>Urgent transport to prevent respiratory failure.</p>	<p>Routine linen management. Decontaminate surfaces with 10% hypochloritic solution.</p> <p>After each patient, disinfect patient care equipment.</p>
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	<p>failure, intact mental state.</p> <p>Gastrointestinal symptoms accompany foodborne botulism. Inhalation botulism does not present with GI symptoms.</p>	<ul style="list-style-type: none"> • Proper hand washing. • N95 respirators or greater until verification that no aerosol delivery occurred. <p style="text-align: center;">STANDARD PRECAUTIONS</p>	<p>If aerosol dispersed, patient decontaminate with soap and water. Supportive therapy; respiratory support.</p> <p>Statewide and Regional EMS Treatment and Transport Protocols.</p>	
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<p>Brucellosis (Bacteria) Method of Infection: Contaminated food Ingestion</p> <p>Incubation Period: 5 days – 2 months</p>	<p>Fever (often intermittent) headache, chills, heavy sweating, joint pain.</p> <p>Most common findings are lymph node disease and enlargement of the spleen.</p> <p>Systemic illness may become chronic with fever and weight loss.</p> <p>May have pus-foaming lesions. Bone/joint pain common.</p>	<p>Transmission: Person-to-person transmission is rare. Ingestion</p> <p>Personal Protection Equipment & Precautions:</p> <ul style="list-style-type: none"> • Gloves • Respiratory mask N95 or greater. • Proper hand washing. <p style="text-align: center;">AIRBORNE PRECAUTIONS</p>	<p>No transport restrictions. Supportive therapy.</p> <p>Statewide and Regional EMS Treatment and Transport Protocols.</p>	<p>Routine linen management. Decontaminate surfaces with 10% bleach solution. Do not use bleach on patient. After each patient, disinfect patient care equipment.</p>
<p>Plague: Pneumonic (Bacteria) Method of Infection: Inhalation Incubation Period: 1 – 6 days</p>	<p>Sudden onset of high fever, chest pain, cough chills, headache, muscle pain, vomiting. Weakness/prostration, swollen lymph nodes. Dyspnea, stridor, cyanosis.</p>	<p>Transmission: Person-to-person transmission via respiratory inhalation and infected flea bites.</p> <p>Personal Protection</p>	<p>Do not perform mouth-to- mouth respirations. Place N95 respiratory mask on patient.</p>	<p>Routine linen management. Decontaminate surface with 10% bleach solution. Do not use bleach on patient.</p>

	Gastrointestinal symptoms. Sputum initially watery, then bloody, rapidly developing pneumonia, cyanosis, shock, rapid death.	Equipment & Precautions: <ul style="list-style-type: none"> • Gloves • Respiratory mask N95 or greater • Eye protection/face shield. • Disposable full-length gown or jumpsuit. • Disposable shoe covers. • Proper hand washing. <p style="text-align: center;">DROPLET PRECAUTIONS</p>	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: <ul style="list-style-type: none"> • 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.

<p>Ricin (Biotxin) Method of Infection: Inhalation, ingestion and injection. Signs/symptoms occur 18-24 hours after</p>	<p>Inhalation: Chest tightness, weakness, fever, progressive cough, pulmonary edema, cyanosis, dyspnea, nausea and joint pain. Allergic/asthma like symptoms: congestion of nose/throat,</p>	<p>Transmission: No person-to- person transmission. Personal Protection Equipment & Precautions: • Gloves</p>	<p>Do not perform mouth-to- mouth respirations No other transport restrictions Airway, Breathing and Circulation.</p>	<p>Routine linen management. Hypochlorite solution 10% sodium hypochlorite. After each patient, disinfect patient care</p>
<p>inhalation exposure; followed by severe respiratory distress and death from hypoxemia in 36-72 hours.</p>	<p>itchiness of eyes, hives. Respiratory distress and death. Ingestion and Injection: Internal bleeding, vomiting and bloody diarrhea. Hallucinations, seizures, low blood pressure.</p>	<p>• Respiratory mask N95 or greater. • Goggles with respiratory protection or full face-piece respirator • Proper hand washing. SPECIAL RESPIRATORY PRECAUTIONS</p>	<p>100% oxygen via nonrebreather. Statewide and Regional EMS Treatment and Transport Protocols.</p>	<p>equipment. Use dry clean up procedures (e.g., hepa vacuum).</p>

<p>Smallpox (Virus) Method of Infection: Inhalation of droplets Contact with shedding virus. Direct contact of infected bodily fluids or contaminated objects.</p> <p>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</p>	<p>Disease On Set: acute onset of discomfort, extreme exhaustion, severe abdominal pain, fever, chills, cough, vomiting, muscle tremors, headache and backache.</p> <p>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.</p> <p>Rash spreads to legs and then centrally to trunk (Week 2)</p>	<p>Transmission: Person-to-person.</p> <p>Personal Protection Equipment & Precautions:</p> <ul style="list-style-type: none"> • 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. <p style="text-align: center;">SPECIAL RESPIRATORY PRECAUTIONS</p>	<p>Do not perform mouth-to- mouth respirations. Use disposable linens.</p> <p>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.</p>	<p>Clean floors using a single bucket procedure of wet mopping using solution.</p> <ul style="list-style-type: none"> • 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
<p>contagious. Person remains contagious until all of the scabs have fallen off.</p>				<p>incinerating.</p> <ul style="list-style-type: none"> • Decontaminate surface with 10% bleach solution. <p>Do not use bleach on patient.</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • Gloves • Respiratory mask N95 or 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. <ul style="list-style-type: none"> • Disposable shoe covers. • Proper hand washing. 	Superactive charcoal if toxin has been ingested.	

<p>Tularemia (Bacteria) Method of Infection: Inhalation. Incubation Period: 3 to 5 days</p>	<p>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.</p>	<p>Transmission: No person-to-person transmission. Personal Protection Equipment & Precautions: <ul style="list-style-type: none"> • 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. </p>	<p>Do not perform mouth-to-mouth respirations. No other transport restrictions</p>	<p>Routine linen management. Decontaminate surfaces with 10% bleach solution. Do not use bleach on patient. After each patient, disinfect patient care equipment.</p>
<p>Viral Hemorrhagic Fevers (Virus) Arenavirus Ebola Filoviruses Method of Infection: Direct contact and inhalation.</p>	<p>Fever, muscle pain, easy bleeding, red itchy eyes, vomiting, bleeding, hypotension, headache, and shock. Delirium, seizures and coma. Diarrhea, flaccid paralysis, weakness.</p>	<p>Transmission: Person-to-person transmission. Personal Protection Equipment & Precautions: <ul style="list-style-type: none"> • Gloves • Respiratory mask (N95 or greater). </p>	<p>Do not perform mouth-to-mouth respirations. Supportive therapy. Statewide and Regional Treatment and Transport Protocols.</p>	<p>Routine linen management. Decontaminate surfaces with 10% bleach solution, hypochlorite or phenolic disinfectants. After each patient, disinfect</p>

		<ul style="list-style-type: none">• Eye protection/face shield • Disposable full-length gown or jumpsuit. <ul style="list-style-type: none">• Proper hand washing. HIGHLY INFECTIOUS DISEASE		patient care equipment.
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APPENDIX B: 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

Patrick Franklin, Lead Epidemiologist
Patrick.Franklin@health.mo.gov
Northwest District Health Office
8800 E. 63rd Street, Suite 600
Raytown, MO 64133
(816) 350-5442
(816) 350-7691 FAX

Jessica Pearson, MPH, Epidemiologist
Jessica.C.Pearson@health.mo.gov
(816) 521-7739

Madison Polry, MPH, Epidemiologist
Madison.Polry@health.mo.gov
(816) 350-5404

John Bos, MPH
Bureau Chief
John.Bos@health.mo.gov
Southwest District Health Office
149 Park Central Square, Ste. 116
Springfield, MO 65806
(417) 895-6945

Nathan Koffarnus, MPH
Assistant Bureau Chief
Nathan.Koffarnus@health.mo.gov
(573) 275-3150

Joseline Hernandez, MPH, Lead Epidemiologist
Joseline.Hernandez@health.mo.gov
Central District Health Office
900 W. Nifong Blvd, Suite 215
Columbia, MO 65203
(573) 441-6242
(573) 441-5050 FAX

Miranda Schloman, MPH, Epidemiologist
Miranda.Schloman@health.mo.gov
(573) 441-6235

Alexandra Berkley, MPH, Lead Epidemiologist
Alexandra.Berkley@health.mo.gov
Eastern District Health Office
220 South Jefferson Avenue
St. Louis, MO 63103
(314) 877-2857
(314) 877-2808 FAX

Nicole Ditto, MPH, Epidemiologist
Nicole.Ditto@health.mo.gov
(314) 877-2832

Wing Lam, MPH, CPH, Epidemiologist
Wing.Lam@health.mo.gov
(314) 877-0237

State Epidemiologists
George Turabelidze, MD, PhD
George.Turabelidze@health.mo.gov
Eastern District Health Office
(314) 877-2826

HAI Coordinator
Amy Pierce, MPH
Lead Epidemiologist/
Coordinator
Amy.Pierce@health.mo.gov
930 Wildwood Drive
Jefferson City, MO 65109
(573) 526-7386
(573) 526-0235 FAX

Greg Moon, MPH
Epidemiologist
Greg.Moon@health.mo.gov
(573) 522-1471

TB Control
Traci Hadley, RN, BSN
TB Controller/
Nursing Consultant
Traci.Hadley@health.mo.gov
1110 East 7th, Suite 12
Joplin, MO 64801
(417) 629-3487
(417) 629-3477 FAX
Regions: A, D, E, G, and H

Bev Myers, RN
Public Health Senior Nurse
Bev.Myers@health.mo.gov
142 Staples Drive
Park Hills, MO 63601
(573) 518-2697
(573) 431-5797 FAX
Regions: B, C, F, and I

Terry Eslahi
Lead Epidemiologist
Program Manager
Terry.Eslahi@health.mo.gov
930 Wildwood Drive
Jefferson City, MO 65109
(573) 751-6113
(573) 526-0234 FAX

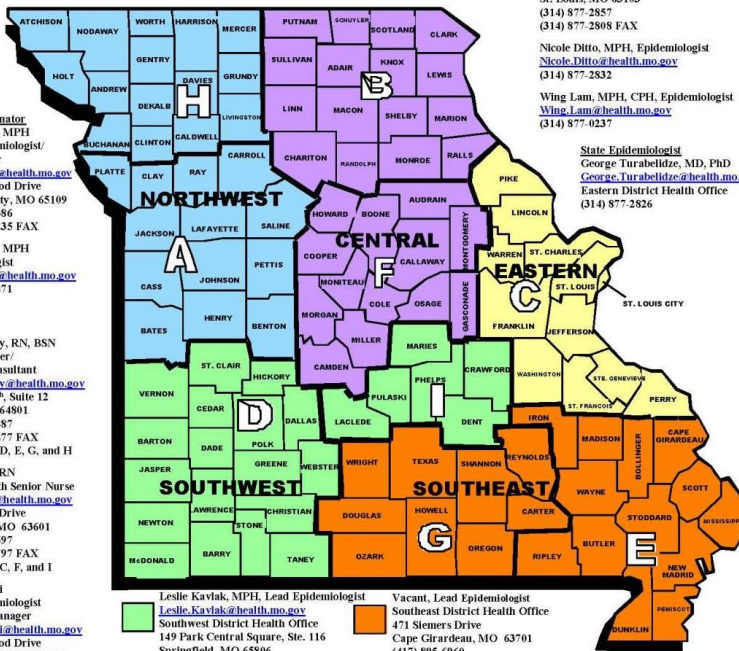
Opeyemi Fasoyitan, MPH, Epidemiologist
Opeyemi.Fasoyitan@health.mo.gov
(573) 751-6113

Leslie Kavvak, MPH, Lead Epidemiologist
Leslie.Kavvak@health.mo.gov
Southwest District Health Office
149 Park Central Square, Ste. 116
Springfield, MO 65806
(417) 895-6916
(417) 895-6959 FAX

Jessica Goswitz, MPH, Epidemiologist
Jessica.Goswitz@health.mo.gov
(417) 895-6918

Vacant, Lead Epidemiologist
Southeast District Health Office
471 Slemers Drive
Cape Girardeau, MO 63701
(417) 895-6960
(573) 290-5195 FAX

Michael Onsongo, MPH, Epidemiologist
Michael.Onsongo@health.mo.gov
Southwest District Health Office
149 Park Central Square, Ste. 116
Springfield, MO 65806
(417) 370-6683



May 2021

APPENDIX C: 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) bgettemeir@cottlevillefpd.org Cottleville Fire Department 314-330-7074 (cell) BGettemeir@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

Hazmat Contact List November 3, 2020

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

Hazmat Contact List November 3, 2020

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

Hazmat Contact List November 3, 2020

Region E

Region E HRST- Type II

Lt. Derick Wheatley 573-471-6200 (work) dwheatley@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 jbstic@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

Hazmat Contact List November 3, 2020

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

Hazmat Contact List November 3, 2020

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

Hazmat Contact List November 3, 2020

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. klaidacker@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*