



**Medical Control Board  
Office of the Medical Director**

**Annual Report from the Medical Director  
Operational & Fiscal Year July 2011- June 2012**

## **Report Structure**

Continuing with this year's Medical Control Board/Office of the Medical Director (MCB/OMD) Annual Report, based upon feedback from key government and EMS system leaders in metropolitan Oklahoma City and Tulsa, the content is structured for efficient and purposeful review of key activities accomplished by MCB physicians, the Medical Director, and OMD professionals.

## **Medical Oversight Design**

The **Medical Control Board** is established by the Emergency Physician Foundations of Oklahoma City (Western Division) and Tulsa (Eastern Division). The Medical Control Board is comprised of eleven physicians devoting volunteer service to the patients served by the EMS system for metropolitan Oklahoma City and Tulsa and to the dedicated men and women rendering emergency medical care as an Emergency Medical Dispatcher, Emergency Medical Technician (EMT)-Basic, EMT-Intermediate, or EMT-Paramedic. By design, emergency physicians constitute all positions on the MCB with the exception of one position designated to be filled by another physician medical specialist. The emergency physicians most typically represent the busiest emergency departments in the areas served by the EMS system. The following physicians served on the MCB during this operational and fiscal year:

*Jeffrey D. Dixon, MD, FACEP* – Hillcrest Medical Center (Tulsa)  
Chair until May 2012

*Jeffrey Reames, MD, FACEP* – Mercy Hospital (Oklahoma City)  
Chair since May 2012; Vice Chair until May 2012

*Michael Smith, MD, FACEP* – St. John Medical Center (Tulsa)  
Vice Chair since May 2012

*Thelma Peery, DO, FACOEP* – Southcrest Hospital (Tulsa)  
Secretary until May 2012; Service until May 2012

*John C. Nalagan, MD, FACEP* – Integris Baptist Medical Center (Oklahoma City)  
Secretary since May 2012

*Brent Barnes, MD, FACEP* – University of Oklahoma Medical Center (Oklahoma City)

*Paul Beck, MD, FACEP* – St. Francis Hospital (Tulsa) – service until Nov 2011

*Mark Blubaugh, DO, FACOEP* – Oklahoma State University Medical Center (Tulsa)

*Jerry Brindley, MD, FACEP* – Deaconess Hospital (Oklahoma City)

*Charles F. Engles, MD, FACS* – Neurosurgeon (Oklahoma City)

*Justin Fairless, DO* – St. Francis Hospital (Tulsa) – service beginning Nov 2011

*Kurt Feighner, D.O., FACOEP* – Edmond Medical Center

The MCB meets bimonthly to review a report from the President of the Emergency Medical Services Authority, a report from the Medical Director, standard of medical care advancements and/or revisions endorsed by the Medical Director, financial statements of the MCB/OMD, and new business brought before the MCB by any interested party.

The **Medical Director** is the day-to-day recognized clinical authority in the EMS system, serving as such between times the MCB is meeting. *Jeffrey M. Goodloe, MD, NREMT-P, FACEP* is the Medical Director for all agencies receiving medical oversight from the MCB/OMD.

Beginning July 1, 2009, the MCB contracted with the Department of Emergency Medicine at the University of Oklahoma's School of Community Medicine for physician medical director services. Substantial benefits to the EMS system and its patients are achieved through this arrangement, bringing research and educational capabilities from the University of Oklahoma, its emergency medicine residency program, and its collegial network of medical professionals.

This year is Dr. Goodloe's third year as Medical Director for the MCB/OMD. For familiarization purposes, his biography can be found in the MCB/OMD Annual Report from the Medical Director for Operational & Fiscal Year July 2009 – June 2010.

The **Office of the Medical Director** is comprised of the following professionals:

*Jeffrey M. Goodloe, MD, NREMT-P, FACEP* – Medical Director

*T.J. Reginald, NREMT-P* – Director of Research & Clinical Standards Development

*David S. Howerton, NREMT-P* – Director of Clinical Affairs Western Division (Oklahoma City)

*Jim O. Winham, RN, BSN, NREMT-P* – Director of Clinical Affairs Eastern Division (Tulsa)

\*Mr. Winham retired from this position effective July 1, 2012

*Tammy Appleby* – Executive Assistant to the Medical Director

OMD professionals work daily to assist public safety agencies charged with emergency medical services responsibilities to fulfill those according to the clinical care standards established by the MCB. Medical outcomes determinations, individual medical care review, personnel education, personnel credentialing, equipment/vehicle performance review and inspection are just some of the myriad activities performed in support of excellence in pre-hospital emergency medical care.

All OMD directors are particularly experienced and gifted clinicians and administrative leaders, guided by admirable work ethic. Each has served this and other EMS systems in a multitude of responsibilities, beginning with field service and progressing to their current oversight duties. Ms. Appleby, also a certified EMT-Basic, continues in her third year of work in the role of Executive Assistant to the Medical Director, responsible for OMD workflow logistics, organization, and spearheading additional service product lines.

### **Philosophy of Medical Oversight**

The provision of emergency medical services is more than public safety in metropolitan Oklahoma City and Tulsa; it is a practice of medicine delegated by the MCB's Medical Director to the over 3,300 non-physician EMS professionals serving the over 1.5 million residents, workers, and visitors of the affiliated cities.

Just as an individual has right to access an educated, qualified, and credential physician providing progressive medical care in times of illness or injury, it is incumbent the EMS system

servicing metropolitan Oklahoma City and Tulsa provide educated, qualified, and credentialed EMS professionals authorized to deliver the finest pre-hospital medical care available. When an individual in this service area experiences sudden, unexpected medical symptoms from relatively benign, though concerning pain, to the extreme severity of cardiopulmonary arrest, he or she can rest assured individuals answering the call for help will be trained and prepared to address the medical situation at hand. This cannot happen without up-to-date, progressive medical treatment protocols and accompanying education and training.

Beginning July 1, 2009, the MCB/OMD committed to bringing its medical treatment protocols to new standards, unparalleled amongst large, urban EMS systems in the United States. Significant numbers of protocols were added, updated, and/or reformatted consistently at every MCB meeting this year. In other words, every two months for the past three years, additional clinical capabilities and care are being provided to the patients needing them most. This commitment to excellence in pre-hospital emergency care reflects the drive and energy of the MCB, Medical Director, OMD professionals, leaders in affiliated fire departments and EMSA, and all field EMS professionals.

### **Key Advances in Medical Treatment Protocols**

*Cardiac Arrest* – multiple specific cardiac dysrhythmia protocols (*Asystole, Pulseless Electrical Activity, Ventricular Fibrillation/Pulseless Ventricular Tachycardia, Cardiac Arrest and Cardiac Arrest Etiologies*) developed and/or reformatted to include the latest science in lifesaving practices.

Specific initiatives were: a) increasing chest compression rates from 100 per minute to 120 per minute and guided per metronome, based upon improved return of spontaneous circulation rates as detailed in Resuscitation Outcomes Consortium (ROC) research. ROC is an American-Canadian research network, involving 11 major metropolitan area EMS systems, collaborating to answer some of EMS medicine's most compelling dilemmas in care options; b) promoting continuity of chest compressions, using proper chest compression mechanics; and c) developing an enhanced "pit crew" model of resuscitation team dynamics, derived from best practices in EMS systems across the United States.

These changes collectively enable the EMS system to function beyond the International Liaison Committee on Resuscitation/American Heart Association guidelines that were released in mid-October 2010, subsequently adopted by the MCB in November of 2010 for system effective use in February 2011. See also the detailed discussion of cardiac arrest care initiatives under the "MCB/OMD Project Initiatives" section.

*Therapeutic Hypothermia* – removing exclusionary criteria to promote more frequent cooling therapy for post-cardiac arrest patients, which in turn promotes better neurologic recovery.

*Multi-Patient Scene/Mass Casualty Incidents* – multiple updates to include use of a system-wide triage system, including a standardized triage tag for patient prioritization and treatment documentation. This represents the first time in the system that all agencies receiving medical oversight from the MCB will be approaching mass casualty incidents with the same medical

paradigm and tools that support the best patient outcomes possible in catastrophic events such as natural weather disasters, chemical releases, and terrorist-induced explosions. Protocol directives are written to be in compliance with the National Incident Management System (NIMS) promulgated by the US Department of Homeland Security's Federal Emergency Management Agency (FEMA).

*Emergency Hemorrhage Control/Tourniquets/Hemostatic Agents*– updating therapeutic intervention instructions for critical interventions in life-threatening hemorrhage. Widespread provisioning of tourniquets, including stocking a minimum of two tourniquets on all fire engines and ambulances, significantly improves abilities to control high-pressure arterial bleeding in extremity wounds. Use of a topical hemostatic agent promotes blood clotting in wounds untreatable by tourniquets, such as penetrating injuries in the chest, abdomen, or groin. Combat Gauze™ was chosen based upon superiority outcomes in multiple US military conducted studies, in both domestic and foreign arenas.

*Non-Invasive Positive Pressure Ventilation* – incorporates a new generation mechanical ventilator capable of supporting invasive airway devices, continuous positive airway pressure, and bi-level positive airway pressure.

*Etomidate* – expansion of formulary to include etomidate for medication assisted intubation. This sedative-hypnotic confers greater dose-response characteristics than midazolam and has less effect on circulation than midazolam. A detailed evidence-based medical literature review was presented by the Medical Director to the MCB during discussion of pharmaceutical options for medication assisted intubation.

*General Supportive Care* – expansion of EMT-Basic scope of practice to include ECG acquisition and transmission and use of waveform capnography. Restructuring completed for clinical standards depiction.

*Trauma and Hypovolemic Shock Supportive Care* – expansion of concepts of primary, secondary, and reassessment surveys. Restructuring completed for clinical standards depiction.

*Patient Prioritization* – inclusion of latest updates for hand injury classifications and the Centers for Disease Control (CDC) Trauma Field Triage Scheme.

*Categorization of Hospitals* – inclusion of two “free-standing” emergency departments (emergency departments not contained within or on a full-service hospital campus) in metropolitan Oklahoma City. The criteria specified for patient transports were developed in cooperation with emergency medicine specialists staffing these facilities. Multiple large, urban EMS systems that are evaluating transporting patients to these types of facilities have requested these criteria detailed by the Medical Director and approved by the MCB.

*Interhospital Transfer* – inclusion of a comprehensive set of instructions care for acute stroke patients during thrombolytic agent transfusion or immediately post-thrombolytic agent transfusion. The protocol was developed in partnership with stroke neurology physician specialists.

*Seizure* – prioritization of intramuscular dosing of midazolam based upon reported findings in a multi-center, national study evaluating optimal EMS care for active, persistent seizures.

*Substance Abuse Poisoning* – restructuring of protocol to highlight treatment priorities and differential assessment for overdoses of opiates, antidepressants, stimulants, street drugs, and cardiotoxic drugs.

*Imminent Childbirth* – restructuring of protocol, with inclusion of further treatment directives for childbirth care of infant and mother, including management of potential childbirth-related complications.

*Intraosseous Access* – complete redesign of protocol, featuring latest generation of equipment being used by EMT-Intermediate and EMT-Paramedics in the EMS system. Additional access option of using the humeral head introduced.

Combitube™ - rescinding use of the Combitube™ airway. While useful as a rescue airway device for years, newer models of rescue airways are now manufactured, conveying increasing reliability of successful placement. Emerging research into multiple types of rescue airways reveals concerns about their effect upon cerebral circulation. Rescinding use of the Combitube™ airway in favor of the previously adopted King LT-D™ model airway favors better cerebral circulation when a rescue airway is warranted.

*Ventricular Assist Device (VAD)* – updating therapeutic intervention instructions for patients with newer generation devices surgically placed to compensate for a failing heart muscle. Integris Baptist Medical Center in Oklahoma City has established one of the highest volume LVAD implantation centers in the United States. This protocol was developed in partnership with subspecialists and their nursing clinicians to support increasing numbers of LVAD patients in the serviced areas. Specific areas of instruction include operation and correction of power supply issues, cardiac arrest treatments, and destination determination instructions.

*Formulary* – multiple protocols updated throughout the year to ensure the formulary is consistent with all clinical treatment protocols. Included updates to *Activated Charcoal, Albuterol, Dextrose 50% and 25%, Diazepam, Diphenhydramine, Glucagon, Haloperidol, Ipratropium Bromide, Lidocaine 2% Viscous Gel, Methylprednisolone, Midazolam, Morphine, Phenylephrine Nasal Spray, Pralidoxime Chloride.*

### **Key Advances in MCB/OMD Administrative & Clinical Policies**

Historically, most administrative actions of the MCB/OMD prior to July 2009 have been “management by memo” in structure. Over time as the EMS system has grown in size and structure, these memos have proven difficult to track, confusing in intent, dated in instruction, and while unintentional, contradictory in direction. In efforts to be more transparent in operation, clearer in administrative and clinically-related expectations, and to better support field professionals, the Medical Director specified creation of a MCB/OMD Policy and Procedural Manual in the 2009 – 2010 operational and fiscal year to accompany the Medical Treatment

Protocols. Like the treatment protocols, this continues to prove a multi-year project due to scope and nature of always advancing the practice of EMS medicine and its oversight.

*EMS Provider Credentialing Policy* – comprehensive policy detailing requirements to obtain and maintain credentialing for all levels of EMS professionals receiving clinical privileges from the Medical Director, as the representative physician of the MCB. Additional qualification subcredentials are included (e.g. Urban Search & Rescue medic, tactical medic).

*System Continuing Education Policy* – issuance of new policy that directs all agencies to submit EMS continuing education (CE) plans to OMD. This policy promotes quality review and approval by the Medical Director of all CE material(s) and instructor(s) before being distributed or taught by approved educator(s).

*Emergency Response Vehicle Policy* – revision prohibiting driving in emergency response mode in opposing traffic to the comprehensive set of emergency vehicle operation requirements for OMD Directors and the Medical Director that meet or exceed local, state, and federal emergency response vehicle operation requirements. This revision mirrors policy of the Oklahoma Highway Patrol.

*Reportable Event Review Policy* – reaffirms how and when OMD Directors and the Medical Director are to be notified regarding clinically related incidents.

### **MCB/OMD Review of System Performance Parameters**

*Response Times* – EMSA calculates and supplies MCB/OMD with monthly performance reports regarding response times by Paramedics Plus, the current contractor for clinical and clinically-related administrative services. All monthly reports supplied to MCB/OMD by EMSA were personally reviewed by the OMD Directors, the Medical Director, and the MCB. All reports indicate aggregate compliance with contracted response time standards. Fire departments, particularly the larger departments, such as Oklahoma City, Tulsa, and Edmond supply their response times for EMS-related calls on a monthly basis as well. These reports are personally reviewed by the OMD Directors and the Medical Director on a monthly basis. All reports indicate reasonable response time performances.

*Hospital-Initiated EMS Diversion Requests* – Paramedics Plus calculates and supplies MCB/OMD monthly reports on the number of hospital-initiated EMS diversions their personnel encountered in ambulance transports. All monthly reports supplied to MCB/OMD by Paramedics Plus were personally reviewed by the OMD Directors, the Medical Director, and the MCB. The majority of reports indicate reasonably desirable control of diversion numbers by hospitals in the service area. In May of 2008, the MCB took action to reduce then-elevating numbers of hospital-initiated EMS diversion requests by instituting a protocol that allows paramedics to override such requests if the patient was clinically stable and had a pre-existing relationship with that hospital, its network, and/or a physician on its active or referring medical staff. The effects of that protocol continue to show positive impact as the EMS system promotes patients receiving continuity of care for better clinical outcomes and fiscal stewardship.

An emerging area of concern related to hospital emergency department patient saturation is EMS “bed delay” times. This time period begins when EMSA EMTs and paramedics arrive in an emergency department with the patient packaged on the stretcher and encounter no available beds in which to transfer the patient for ED care and extends to the time in which a transfer into a bed or chair occurs. The Medical Director advised the MCB of growing concerns, including an initial analysis prepared by EMSA, supporting the anecdotal experiences detailed in daily EMSA Field Operations Supervisor Reports that ambulances were being held, at times, over 1 hour at hospitals.

The problem is more prevalent in Tulsa than Oklahoma City, likely due to fewer hospitals serving its metropolitan area. At its March 2012 meeting, the MCB directed the Medical Director to work with EMSA on preparing further data, specifically defining a “reportable bed delay” as one in which the time interval exceeds 15 minutes of delay. Additional data were reviewed, focused upon the 15+ minute bed delays at the MCB May 2012 meeting. The Medical Director also reviewed these concerns with the EMSA Board of Trustees at its June 2012 meeting, with a subsequent article covering these concerns appearing in the Tulsa World newspaper.

*Trauma Priority & Destination Reports* – Paramedics Plus calculates and supplies MCB/OMD monthly reports detailing the numbers and percentages of trauma patients by priorities (One, Two, or Three) and destinations. All monthly reports supplied to the MCB/OMD by Paramedics Plus were personally reviewed by the OMD Directors, the Medical Director, and the MCB. All reports indicate continuance of the following: 1) Priority One Trauma patients comprise <15% of traumas on a monthly basis, with most months seeing <10%. 2) Documentation supporting patients identified as Priority One Trauma is typically at or above 90%. 3) Destination for Priority One Trauma patients is appropriately selected at or above 98% of the time. Deviations from appropriate destination selection are reviewed with individual paramedics making those deviations.

*Clinical Continuous Quality Improvement Agency Reports* – Paramedics Plus and fire department EMS liaisons calculate and supply MCB/OMD monthly reports detailing the activities related to EMS in the respective agency. All agencies with EMT-Intermediates and EMT-Paramedics regularly adhere to the requirements to supply these reports. Content is comprised of call types and volumes, airway management performance, cardiac arrest management performance, intravenous access performance, pharmaceutical utilization, and educational initiatives. All monthly reports supplied to the MCB/OMD by these agencies with advanced life support capabilities were personally reviewed by the OMD Directors and the Medical Director. These reports consistently reflect that agency personnel are meeting or exceeding the clinical expectations of MCB/OMD. Summary statements of these reports are either reported to the MCB by Dr. Goodloe and/or the full agency reports are available for review to any MCB physician at their request. Smaller, basic life support fire departments are varied in their reporting consistencies. OMD Directors and the Medical Director continue to work with these departments to facilitate timely and consistent reporting of their activities.

*Cardiac Arrest Outcomes* – The EMS System for Metropolitan Oklahoma City and Tulsa continues to achieve enviable outcomes in cardiac arrest. Whereas the national average for survival from out-of-hospital cardiac arrest (witnessed arrest, bystander CPR, and shockable



cardiac dysrhythmia upon EMS arrival) remains at 6.4%, outcomes in Oklahoma City and Tulsa are several times this national aggregate performance. Calendar year 2011 data are being finalized at the time of this report, but are expected to be consistent with prior year's performance. Importantly, survivors of cardiac arrest in our area are most frequently able to return to their previous quality of life, neurologically intact and enjoying family and work endeavors.

*Response Vehicle Inspections* – OMD Directors continue to inspect new emergency medical response vehicles, such as fire engines and ambulances, to ensure correct medical equipment provisioning and condition. Few deficiencies are typically discovered and immediately corrected when found.

### **MCB/OMD Project Initiatives**

*Cardiac Arrest Outcomes Optimization Program (aka "50/50" Program)* – Building upon the EMS system's pattern of admirable success in aggressively resuscitating cardiac arrest victims, the MCB promulgated increasingly sophisticated resuscitation team dynamic protocol standards. These standards detail optimal team role performances to maximize chest compression fraction time, reduce delays in timely defibrillation, and achieve coordinated efforts in lifesaving. OMD professionals and the Medical Director personally trained over 3,000 EMS professionals in proper chest compression mechanics at fire station and EMSA classroom levels, utilizing one-on-one intensive training methods, incorporating immediate feedback compression manikins, metronomes, and personal demonstration techniques.

Team dynamics were reviewed in part during these training sessions and a detailed training video was produced by the Oklahoma City Fire Department Video Production Unit (special acknowledgement to Juan Gaona) with assistance from OCFD EMS training staff, select EMSA EMTs and paramedics, OMD Directors, and the Medical Director. This training video has and will continue to be used to illustrate the capabilities of a "pit crew" clinical performance model in cardiac arrest.

The final of three components of the program involves increased performance feedback to involved personnel. Proprietary software analysis of resuscitation actions can be achieved and shared with crew members involved in an individual resuscitation, with a goal for near immediate modification of actions warranting improvements and affirmation of already optimal care practices. Initial reviews have generally yielded impressive levels of performance.

The EMS system has shown abilities to produce approximately 38% neurologically intact survival among victims experiencing a citizen witnessed, citizen CPR initiated, and EMS discovered shockable cardiac rhythm upon their arrival. While very good in its impact upon cardiac arrest survival, the MCB/OMD has stated a system goal of achieving 50%+ survival in the same patient types in both metropolitan Oklahoma City and Tulsa, thus the program's "50/50" description.

*Coordinated Continuing Education* – Prior to July 2009, OMD did not have consistent interaction and oversight of continuing education in the EMS system. The results, without a hub

of coordination, have proven that agencies are pursuing disparate educational initiatives, resulting in educational message inconsistencies. While challenging to correct in short order, OMD began meeting with educational leaders in affiliated agencies willing to attend new educational forum meetings on a monthly basis. All affiliated agencies have been encouraged to send their EMS educational leaders to this forum. Work has progressed and educational materials are more consistently being created and shared for multi-agency use. The results will promote consistency in educational messaging and consistency in timing of education material distribution throughout the EMS system, thereby promoting better integration of treatment plans between fire-based and EMSA-based EMS professionals.

*EMS Professional Credentialing Testing* – OMD Directors, with oversight by the Medical Director, continued the practice of verification of clinical skills performance and knowledge base testing of all professionals on a biannual basis. Extensive rewriting of all personnel credentialing written examinations was performed with direct involvement of the Medical Director. Work is progressing on creating a computer-based testing platform that will allow for more efficient testing access and completion for EMS professionals and OMD professionals alike.

*EMS System Promotion* – Metropolitan Oklahoma City and Tulsa is blessed with the multitude of dedicated EMS professionals in its EMS system. Dr. Goodloe, with endorsement by the MCB, has continued a purposeful plan to better recognize the achievements of these EMS professionals. Academic writing, system-based research with outcomes presentations at scientific assemblies and acceptance of EMS conference speaking invitations are routinely conducted to promote this fine EMS system. The cumulative results advance the interests of patients, EMS professionals, and the cities within the service area.

*Response Configurations* – When a caller dials 911 with a medical complaint in metropolitan Oklahoma City or Tulsa, that complaint is able to be coded into one of approximately 1,200 condition acuity determinants established within the Medical Priority Dispatch System (MPDS), a proprietary medical dispatch software system. MPDS is the most widely utilized such system in developed countries around the world and is supported by evidenced-based medicine. Version 12.1 of MPDS has been adopted by the MCB in specifying clinically appropriate utilization of fire response resources, while attempting to keep as many resources available in service for highest acuity medical responses and non-medical roles (fire suppression, hazardous materials, specialized rescue, and training). The design is to promote the usually closest fire apparatus is available for response to the scene of particularly serious, time-sensitive medical emergencies, such as cardiac arrest, unconsciousness, or gunshot wounds to the chest or abdomen. The criteria utilized to determine whether fire response was selected and agreed to by the affiliated fire departments. All specific call type determinant codes were individually reviewed by the OMD Director of Research and Clinical Standards Development to evaluate for 5% or greater transport to hospital necessitating lights and sirens by paramedic judgment. If so, the determinant code was identified as requiring fire department response. This criterion is weighted toward patient safety, as the MPDS trigger for fire department response is at 10% or greater need for lights and sirens by historical database review of other systems using MPDS. An additional query was conducted to review if any cardiac arrests were discovered for a unique MPDS determinant code and if present, that code was also generally identified as requiring fire department response. Many, though not all, fire departments receiving medical oversight from MCB/OMD have

adopted these specifications into their response policies, with an effect of responding on approximately 65% of all EMS related calls received by the EMS system. OMD Directors and the Medical Director continue to work with fire departments awaiting further city-enabled dispatch abilities before adopting the clinical specifications from the MCB.

*Strategic-Based EMS Blueprint Steering Committee Leadership* – The Medical Director leads efforts in both metropolitan areas to meet with steering committees working from the strategic-based EMS blueprints for both Oklahoma City and Tulsa. Ongoing projects include better communications connectivity between fire-based and EMSA-based computer aided dispatching, on-scene conflict resolution training and implementation of best practices, and disaster medical response training.

*Research Leadership and Support* – The Medical Director and the OMD Directors led and participated in multiple scientific studies throughout the year conducted by the EMS Division of the Department of Emergency Medicine at the University of Oklahoma School of Community Medicine. These studies were consistently selected for presentation at the National Association of EMS Physicians Annual Meeting and Scientific Assembly. Costs for the presentations were borne by the OU Department of Emergency Medicine, without cost to the EMS system.

### **Directions for Operational & Fiscal Year 2010-2011**

The upcoming year will be filled with continuation of the multitude of projects identified in this report as well as additional advancements and revisions to clinical standards of care. Cardiac arrest resuscitative care will continue to be a hallmark of intervention efforts over the coming year.

A comprehensive website for the MCB/OMD is being completed at the time of this report. Through a competitive bid process designed and conducted by the Executive Assistant to the Medical Director, a website design firm was chosen. The Oklahoma City area-based design team at Set Sail Media is actively at work constructing a multitude of resource pages for EMS professionals accessing the website. The provider credentialing testing program will also be accessible through this website.

(Note: There are no pre-existing financial relationships between Set Sail Media and any member or relative of any member of OMD, including the Medical Director.)

In sum, this past operational and fiscal year has seen tremendous energies and enthusiasms evident from MCB/OMD. Similar commitments and enthusiasms have been mirrored by many of the EMS leaders and liaisons in affiliated agencies. Continued effective working relationships between affiliated agencies and MCB/OMD have resulted in the two achievements that matter most:

1 – High quality EMS clinical care for the spectrum of acute illness and injury patients.

2 – Determined, agency-neutral support for the EMS professionals providing high quality EMS clinical care.

During the prior operational year, the Medical Director adopted the following philosophy of his Seattle counterpart:

#### On Achieving Success

“There is no ‘silver bullet’. There is just hard work”

*Michael Keyes Copass, MD.*

This sentiment continues to be found in prominent position upon every desk at which work is performed by the Medical Director, the OMD Directors, and the Executive Assistant to the Medical Director. It will remain in such places throughout Dr. Goodloe’s tenure as the Medical Director, serving as a constantly visible reminder of the expectations in meeting the incredible trust afforded to MCB/OMD by the patients we serve.

Hard work, focused enthusiasm, and the relentless pursuit of optimal clinical care and outcomes continue to advance both the science and art of EMS medicine in the EMS System for Metropolitan Oklahoma City and Tulsa. We enter Operational & Fiscal Year July 2012 – June 2013 convinced it will be the finest in the history of the MCB/OMD.