



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

**Annual Report from the Medical Director
Operational & Fiscal Year July 2012- June 2013**

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 Responder, Emergency Medical Technician (EMT)-Basic, EMT-Intermediate, Advanced EMT, 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 busier emergency departments in the areas served by the EMS system. The following physicians served on the MCB during this operational and fiscal year:

Jeffrey Reames, MD, FACEP – Mercy Hospital (Oklahoma City)
Chair

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

John C. Nalagan, MD, FACEP – Integris Baptist Medical Center (Oklahoma City)
Board Member and Secretary until January 2013

Chad Borin, DO, FACOEP – St. Anthony Hospital (Oklahoma City)
Board Member and Secretary since May 2013

Jennifer Amen, MD, MPH, FAAEM – Hillcrest Hospital South (Tulsa)
Board Member since January 2013

Brent Barnes, MD, FACEP – University of Oklahoma Medical Center (Oklahoma City)
Board Member until May 2013

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

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

Stewart Coffman, MD, FACEP – University of Oklahoma Medical Center (Oklahoma City)
Board Member since May 2013

Jeffrey D. Dixon, MD, FACEP – Hillcrest Medical Center (Tulsa)

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

Justin Fairless, DO, FAAEM – St. Francis Hospital (Tulsa)

Kurt Feighner, DO, FACOEP – University of Oklahoma Medical Center Edmond
Board Member until May 2013

David Smith, MD – Integris Baptist Medical Center (Oklahoma City)
Board Member since May 2013

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 fourth year as Medical Director for the MCB/OMD. For familiarization purposes, and for space considerations, 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

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

Duffy McAnallen, NREMT-P – Director of Clinical Affairs Eastern Division (Tulsa)

*Effective since September 24, 2012

Howard Reed, NREMT-P – Director of Research & Clinical Standards Development

*Effective since January 2, 2013

Tammy Appleby – Executive Assistant to the Medical Director

Dinorah Rivera – Data Entry Specialist

*Effective since August 31, 2012

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

*Effective until October 2, 2012

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 fourth 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. The newly developed position of the Data Entry Specialist is held by Ms. Rivera, responsible for inputting critical clinical data for enhancing mission development and research.

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 3,500 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 credentialed physician providing progressive medical care in times of illness or injury, it is incumbent the EMS system serving 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 four 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.

The commitment in progressively developing medical treatment protocols in this EMS system has been clearly recognized by the Oklahoma State Department of Health (OSDH). OSDH has initiated a working relationship with the Medical Director and the University of Oklahoma Department of Emergency Medicine's EMS Section to develop an innovative, evidence-based medicine, comprehensive set of treatment protocols for use by all EMS agencies in Oklahoma. This protocol set, released in October 2012 and implemented in January 2013 is also the primary protocol set utilized in this EMS system today. Many EMS systems within the United States and abroad currently index their standards of care to this set of treatment protocols. The patients of this EMS system can rest assured they are receiving the very best in pre-hospital emergency medical care.

Key Advances in Medical Treatment Protocols

2013 State of Oklahoma EMS Treatment Protocol Set – The Medical Control Board adopted the entirety of this innovative, evidence-based medicine treatment protocol set, just described above, with exclusions of the following protocols: 2F – Combitube Airway; 5L – Hypertensive

Emergency; 16L – Hydralazine; 16Y – Labetalol; 16HH - Norepinephrine. Adoption of this set now means that all medical treatment protocols being utilized in June 2013 have been reviewed within the immediate year. Additionally, with adoption of this set, all protocols have been reformatted to clearly indicate the allowed scopes of practice for each recognized level of EMS professional and the procedural protocols have become more graphic intensive, designed to facilitate accurate performance of critical skills, particularly those required in rarer patient conditions.

Supraglottic Airways – Addition of King LTS-D airway to allow for gastro-esophageal suctioning to further reduce risk of aspiration during airway use and with airway removal.

Tachycardia – Stable – Addition of on-line medical control physician authorization for diltiazem administration for atrial fibrillation/flutter with ventricular rates greater than 150 beats per minute.

Stroke – Extension of early notification window from within 3 hours of acute symptom onset to within 6 hours of acute symptom onset, particularly when transporting to a hospital with stroke care capabilities beyond peripheral intravenous thrombolytics.

Acute Allergic Reaction, Snakebites, and Bee/Wasp Stings & Fire Ant Bites – Change in anaphylaxis criteria to include hypotension (cardiovascular collapse) alone. The dose of IM epinephrine for adults was also increased from 0.3mg to 0.5mg to follow the 2012 guidance of the World Allergy Organization and the American Academy of Asthma, Allergy, and Immunology. Additionally, the administration of non-autoinjector epinephrine was moved to the Advanced EMT scope of practice.

Emergency Hemorrhage Control/Hemostatic Agents– Updating therapeutic intervention instructions for critical interventions in life-threatening hemorrhage. Addition of tranexamic acid for traumatic hemorrhagic shock. The EMS System for Metropolitan Oklahoma City and Tulsa is the first large, urban EMS system in the United States to approve the use of tranexamic acid administration by paramedics. This protocol was developed using well-designed studies conducted in Europe and in middle Eastern military conflicts. The protocol was approved by trauma surgeons at each of Oklahoma’s Level I or II trauma centers. Early tranexamic acid administration offers the hope of increased survival from the most serious traumatic injuries. Many EMS systems around the world are indexing their adoption of tranexamic acid from this protocol and are inquiring about our current experience with the use of tranexamic acid in EMS.

Categorization of Hospitals – Updating clinical capabilities at hospitals in metropolitan Oklahoma City and Tulsa, such as expanded stroke care capabilities at St. Anthony Hospital and St. Francis Hospital.

Hospital Initiated EMS Diversion – Adding diversion criteria to allow for diversion request for temporary loss of cardiac catheterization lab services, as may occur during preventative maintenance or physical plant disasters.

Formulary – Multiple protocols updated throughout the year to ensure the formulary is consistent with all clinical treatment protocols, including indexing all formulary protocols to individual treatment protocols and clearly delineating use by scope of practice per EMS credential.

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.

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.

During the course of this year, the MCB/OMD advised EMSA to recalculate the requirements of response times for its contractor RFP, based upon the OU Department of Emergency Medicine Evidence-Based System Design White Paper. Specific areas of review included response configurations (when to activate Fire Department response), response modality (when to require use of lights and sirens during response, with an emphasis to reduce such use for safety of responders and the traveling public, based upon scant, if any, clinical benefit of such use), and response times (recommendation to allow an additional 2 minutes of response time of the transport ambulance in Priority 1 and Priority 2 calls), staffing configuration (support for the 1+1 model, being one paramedic per ambulance and one paramedic per Advanced Life Support fire apparatus), and shift schedules (continued support for 12 hour maximum ambulance shifts and for 24 hour maximum fire apparatus shifts).

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.

In July, the Medical Director communicated with leadership at all hospitals in the metropolitan Oklahoma City and Tulsa areas regarding these concerns. Further individual facility data analysis revealed difficult to obtain accuracy in quantifying and qualifying individual bed waits. The continued anecdotal overview of this issue reveals that daily bed waits often occur, though the problem appears to be improving due to more aggressive EMSA-initiated ED saturation diversion practices and some modest changes in hospital admission/ED offload policies. The MCB/OMD will continue to be vigilant in the issue. Worsening effects may require a more formal approach in quantifying and qualifying individual bed waits though the posting of human data recorders in dedicated research in selected emergency departments, though even in brief periods of time, could prove costly.

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.

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.

Cardiac arrest resuscitation team dynamics continue to be reinforced during continued education for all current EMS professionals in the system and are reviewed in focused detail during the orientation for all EMS professionals joining this system.

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 that generally yielded impressive levels of performance continue to be frequently replicated. The Medical Director and Director of Research and Clinical Standards Development attended the world-renowned Resuscitation Academy at Seattle/King County, Washington in March. The faculty of this academy spontaneously commented on the

success in cardiac arrest resuscitation achieved in metropolitan Oklahoma City and Tulsa and encouraged our EMS system to develop its own Resuscitation Academy in the model of Washington's . We anticipate such development in the 2-3 year timeframe with the assistance of that academy's faculty. This will allow our EMS system to share its success with students from around the world, highlighting our clinical and educational abilities.

The EMS system's dedicated efforts results in a 42.6% survival among cardiac arrest victims experiencing a citizen witnessed, citizen CPR initiated, and EMS discovered shockable cardiac rhythm upon their arrival in calendar year 2011. Nearly 90% of these survivors were discharged from the hospital in neurologically intact status, able to largely or completely resume their lives prior to cardiac arrest. Calendar year 2012 data is actively being evaluated at the time of this report, including formal research into the resuscitative practices being conducted by the OU Department of Emergency Medicine's EMS Section, also led by Dr. Goodloe.

While these most recent results reflect exemplary 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, with implementation expected in beta format November 2013 and fully live in January 2014.

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, American College of Cardiology, and the Canadian Association of Emergency Physicians Annual Meeting. Costs for the presentations were borne by the OU Department of Emergency Medicine, without any significant cost to the EMS system.

Directions for Operational & Fiscal Year 2013-2014

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 has been activated in the last year and further generational updates will be completed in the coming year, including a companion Smartphone and portable tablet application, predominately allowing ease of protocol access for all EMS professionals at no cost to them. The provider credentialing testing program will be accessible through the MCB/OMD website.

(Note: There are no pre-existing financial relationships between Set Sail Media, developer of the website and application, 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 past two operational years, 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 2013 – June 2014 convinced it will be the finest in the history of the MCB/OMD.