90-30

EMS Interlocal Cooperation Agreement

WHEREAS, the State of Oklahoma, in the Interlocal Cooperation Act, has provided in Title 74 O.S., Sec. 1001, 1981 et seq., that governmental entities may jointly exercise with other local governmental entities the power to provide governmental services for the public health and welfare; and,

WHEREAS, it is in the best interests of the public health and welfare of the people of the member jurisdictions of the EMS Interlocal Cooperation to have available to them a state-of-the-art, high quality, EMS system, with effective medical controls and accountability, and adequate response times; and,

WHEREAS, the repetitive inspections of vehicles and on-board equipment for purposes of permitting by numerous local jurisdictions is an inefficient allocation of scarce governmental personnel and resources, and creates an unnecessary danger to the public by the removal of ambulances from service during such multiple inspection periods; and,

WHEREAS, the repetitive testing for licensure of EMS personnel by numerous local jurisdictions imposes an unreasonable burden upon the EMS personnel and their employers, and creates an unnecessary danger to the public by removing previously licensed persons from service during the testing periods, and repetitive testing of personnel is an inefficient use of scarce resources; and,

WHEREAS, the quality of emergency medical services (EMS) should not depend upon municipal boundary lines; and,

WHEREAS, a unified, coordinated system of medical oversight and control of EMS throughout an urban area without regard to political subdivision boundaries is in the best interests of the health, welfare, and safety of the citizens of all member jurisdictions of this EMS Interlocal Cooperative; and,

WHEREAS, it is in the best interest of the health, welfare, and safety of the citizens the member jurisdictions of this EMS Interlocal Cooperative for such member jurisdictions to join together in creating a multi-jurisdictional "Regulated Service Area," and a "Medical Control Board" to provide informed, objective, and clinically expert oversight of the quality of care and

response time performance provided by the various components of the EMS system throughout the Regulated Service Area, as defined herein; and,

WHEREAS, ambulances and crews normally based in different communities are often called upon to function in concert at the scenes of multiple casualty incidents, during which times crew members become "teamed" with crew members from another area and must necessarily utilize the complex medical equipment brought to the scene by other crews; an extreme danger to the public is created when such personnel are trained and accustomed to working with different brands and types of medical equipment than those available for their use at that moment; and,

WHEREAS, the State of Oklahoma and its political subdivisions have experienced revenue shortfalls in the recent past creating hardships for the funding of governmental services; and,

WHEREAS, it is in the best interests of the citizens of Oklahoma to have their tax dollars spent in the most cost efficient means; and,

WHEREAS, Title 74 O.S. Sec. 1001 1981 et seq., allows local governmental units to make the most efficient use of their powers by enabling them to cooperate with other localities on a basis of mutual advantage and thereby to provide services and facilities in a manner and pursuant to forms of governmental organization that will accord best with geographic, economic, population, and other factors influencing the needs and development of local communities; and,

WHEREAS, it will result in substantial savings of tax dollars to designate a single entity to do vehicular inspections, testing, and to generally monitor and oversee the operation of the EMS system.

THEREFORE, be it resolved that the undersigned jurisdictions do hereby agree to join together to create an EMS Interlocal Cooperative, and further agrees as follows:

1. Requirements for Membership. Requirements for joining the EMS Interlocal Cooperative shall include all of the following:

A. The applicant jurisdiction shall approve and execute this EMS Interlocal Cooperation Agreement.

B. The applicant jurisdiction shall adopt and enforce the Uniform EMS Ordinance which is attached hereto as Exhibit A, "Uniform Ordinance for Emergency Medical Services", and as that ordinance may be amended by the Beneficiary Jurisdictions as defined below in paragraph C of Section 2.

C. Upon adopting the Uniform EMS Ordinance, the applicant jurisdiction may, at its option and by separate ordinance, substitute less stringent response time requirements than the Ordinance's standard response time requirements. Except for modifications related exclusively to response time requirements, any other changes to that Uniform Ordinance made by a jurisdiction shall result in automatic disqualification for membership in this EMS Interlocal Cooperative.

D. The applicant jurisdiction shall be and remain throughout the term of this Agreement a Beneficiary or Non-Beneficiary Member Jurisdiction as defined by the terms of the Amended and Restated Trust Indenture (Exhibit B).

2. **Definitions:** For purposes of the Agreement, the following definitions shall apply:

A. **Ambulance Service Provider** means EMSA's then-current Operations Contractor, and any other organization which is issued a permit by the Licensing Officer pursuant to the requirements of the Uniform Ordinance for Emergency Medical Services (Exhibit A).

B. **Amended And Restated Trust Indenture** is that document attached hereto as Exhibit B and adopted of even date herewith by the City of Tulsa and as adopted and as amended or superseded by the beneficiary jurisdictions.

C. **Beneficiary Jurisdictions** shall have the definition set forth in Article VIII Sec. 1 of the Amended And Restated Trust Indenture (Exhibit B).

D. **Contract for Special Arrangements** means the contract which operates between EMSA and a jurisdiction served by EMSA which defines the terms of any special arrangements which have been agreed to regarding subsidy, fee schedules, or response times within that jurisdiction.

E. **Emergency Medical Services (EMS) System** means those organizations, individuals, facilities and equipment which participate directly in the delivery of EMS, as defined in the Uniform Ordinance for Emergency Medical Services (Exhibit A), throughout the Regulated Service Area.

F. **EMSA** means the Emergency Medical Services Authority, a public trust whose beneficiaries are the City of Tulsa and, subject to acceptance of beneficiary status, the City of Oklahoma City.

G. **EMS Interlocal Cooperation Agreement** means this agreement, hereinafter referred to as "Agreement".

H. **Licensing Officer** means the public official whom each Beneficiary Jurisdiction designates and empowers to issue permits, as defined in the Uniform Ordinance for Emergency Medical Services (Exhibit A), in accordance with policies, procedures, and standards governing such issuance set forth herein and in the Uniform Ordinance for Emergency Medical Services.

I. **On-line Medical Control Physician** means a physician certified by the Medical Control Board to direct patient care in the field by way of radio or telephone communications.

J. **Operations Contract** means the contract for purchase of ambulance services between EMSA and its then-contracted firm (the "Operations Contractor") for provision of ambulance services throughout the Regulated Service Area.

K. **Quality Assurance Fund.** That fund account which is administered by EMSA on behalf of the Medical Control Board, and which shall be used solely to fund the activities and expenses of the Medical Control Board in carrying out the purposes set forth in this Agreement.

L. **Regulated Service Area** means the geographic area which is contained within the boundaries of the municipalities which have adopted and agreed to enforce the Uniform Ordinance for Emergency Medical Services, and which have approved this Agreement.

M. **System Standard of Care** means the written body of standards, protocols, and policies governing clinical aspects of the EMS system, including:

1. **Input standards** (e.g., personnel certification requirements, in-service training requirements, equipment specifications, on-board inventory requirements, and other requirements which the EMS system must fulfill before receipt of a request for service);

2. **Performance standards** (e.g., priority dispatching protocols and pre-arrival instructions, medical protocols, standing orders, response time standards, data and record-keeping requirements and methods, and other performance specifications describing how the EMS system should perform upon receipt of a request for service); and,

3. **Outcome standards** (e.g., target survival rates for certain for certain narrowly defined presenting problems or presumptive diagnoses, such as witnessed cardiac arrests involving patients whose medical histories meet defined criteria). Outcome standards define the results the system intends to achieve by meeting its "input" and "performance" standards.

For purposes of this definition, the response time standards set forth in the Uniform Ordinance for Emergency Medical Services (or, if applicable, in the Contract for Primary Ambulance Coverage) adopted by each jurisdiction which is a member of this EMS Interlocal Cooperative shall be automatically incorporated into the System Standard of Care as the response time standard applicable to calls originating from within each respective jurisdiction.

N. **Uniform Ordinance for Emergency Medical Services** means that ordinance attached hereto as Exhibit A of even date herewith by the City of Tulsa and as adopted, amended or superseded thereafter by the Beneficiary Member Jurisdictions.

3. **Emergency Physician's Foundation -- Creation and Purpose.** There is hereby created a governmental administrative agency, pursuant to 74 O.S., Sec. 1001, et seq., 1981 called the Emergency Physicians Foundation (hereinafter called the "EPF"). The EPF shall have the powers and duties set forth and described in Section 9, below. It is the purpose of the EPF, acting through its elected Medical Control Board, to oversee clinical aspects of the EMS System

throughout the Regulated Service Area. The Medical Control Board shall be established as provided in Section 12, below; and shall have the powers and duties set forth and described in Section 13, below.

4. **Duration of the EPF.** The EPF shall continue to exist so long as this Agreement remains in effect between two or more jurisdictions which meet the qualifications set forth in Section 1, above.

5. **Chapters of EPF.** There shall be two chapters of the EPF, one for the "Eastern Division" and one for the "Western Division," as those Divisions are geographically defined in the "Amended and Restated Trust Indenture," which is attached hereto as Exhibit B.

6. **Initial Membership in EPF Chapter.** Membership in each Chapter of the EPF shall be limited to physicians who are Board Certified by the American College of Emergency Medicine.

A. **Eastern Chapter.** The Eastern Chapter shall be initially be composed of the Medical Director (or his permanent physician designee) from each Code 1 Hospital in the Eastern Division, as determined by the then-existing Emergency Physician's Foundation and approved by the City of Tulsa in 1978.

B. **Western Chapter.** The Western Chapter shall be initially composed of the Medical Director (or his permanent physician designee) of each Comprehensive Emergency Treatment Center located within the Western Division, as such designation is defined and approved by the Greater Oklahoma City Hospital Council and the EMS Subcommittee of the Oklahoma County Medical Society.

7. **Changes in Membership Requirements.** Over time, changes may occur in certain federal, state, or hospital industry standards applicable to emergency receiving facilities, and in the official mechanisms by which compliance with such standards is judged. When and if such changes do occur, the Medical Control Board, subject to a 2/3 affirmative vote by the both chapters of the EPF, may recommend an amendment to the facility-related qualifications for EPF membership as set forth in Section 6, above, to be consistent with then-current federal, state, or industry standards, which amendment shall become effective 30 days after receipt and filing with the clerk of each member jurisdiction.

8. EPF -- Chapters -- Bylaws and Officers. Each Chapter of the EPF shall adopt its own bylaws and elect its own officers.

9. Powers and Duties of the Chapters. Each Chapter of the EPF shall have the following powers and duties:

A. To elect four members of the EPF to the Medical Control Board; and,

B. To approve patient transport protocols applicable within its respective Division of the Regulated Service Area.

10. Medical Control Board Established. The Medical Control Board shall serve as the regulatory, policy-setting and fact-finding body for the EPF in providing medical oversight of the operations of the EMS System throughout the Regulated Service Area, and shall constitute the Board of Directors of the EPF.

11. Membership on the Medical Control Board. Except for the "ninth" member of the Medical Control Board (as specified in Subsection 12, E below), membership on the Medical Control Board shall be limited to physicians who: are appointed by their respective chapters of the EPF; are members of the EPF; are Board-certified by the American College of Emergency Physicians; and, are engaged full-time in the practice of emergency medicine, as defined by the American College of Emergency Physicians.

12. Elections to the Medical Control Board. There shall be nine members of the Medical Control Board, selected as follows:

A. Both the Eastern and Western Chapters of the EPF shall elect four members of their respective chapters of the EPF to membership on the Medical Control Board.

B. The members of each Chapter of the EPF receiving the most votes shall be elected to a four-year term; the member receiving the second-highest vote total shall be elected to a three-year term; the member receiving the third highest vote total shall be elected to a two-year term; the member receiving the fourth highest vote total shall be elected to a one-year term. Any tie shall be resolved by lot.

C. Thereafter, all terms of office on the Medical Control Board shall be for a period of four years.

D. In all elections for the Medical Control Board, each member of the EPF shall have one vote.

E. The eight elected members of Medical Control Board shall meet and elect one physician, licensed in Oklahoma, who is board-certified in a specialty involved with emergency medicine (e.g., surgery, cardiology), and who shall be selected for a four-year term on the Medical Control Board.

13. Powers and Duties of the Medical Control Board. The Medical Control Board shall have the following powers and duties:

A. To approve the appointment of a Medical Director, who shall serve at the pleasure of the Medical Control Board.

B. To establish an *initial* System Standard of Care, as defined herein and in Exhibit A, Uniform Ordinance for Emergency Medical Services, by integrating the two sets of standards of care in effect as of April 15, 1990 in Tulsa and Oklahoma City; provided, however, that such initial System Standard of Care shall not be less than or in contravention of the minimum standards required by the laws of the State of Oklahoma. Such initial System Standard of Care shall be submitted to the governing bodies of the Beneficiary Member Jurisdictions for approval. Thereafter such standards shall be filed with each Non-Beneficiary Member Jurisdiction.

C. To subsequently enhance the System Standard of Care by incorporating advancements which become known and available from time to time, or to correct defects in the System Standard of Care discovered as a result of the quality assurance monitoring program, as described in Subsection E of this Section 13. However, no change shall be made in the System Standard of Care which results in a standard that is less than or in contravention of the minimum standards required by the laws of the State of Oklahoma. Changes in the System Standard of Care shall be approved by way of the following nine-step process:

Step 1. Submit a "Standard of Care Suggestion." A "Standard of Care Suggestion" shall first be submitted to the Medical Director. The form employed for this purpose shall include, at a minimum, the following information:

a) name(s) and position(s) of person(s) initiating the suggestion;
b) a description of the current standard or practice, and the change being suggested;
c) potential advantages of the change;
d) type of change (e.g., change to "input standards," "performance standards," or both);
e) origin of suggestion (e.g., recently published research, personal experience, local medical audit, experience of other system, etc.);
f) listing of other EMS systems currently using the suggested standard (with contact names, if available);
g) summary of related research, with references;
h) objections likely to be raised in regard to this suggestion.

Step 2. Medical Director's Preliminary Review. Once a suggestion has been received by the Medical Director, and expanded or clarified by its originator if requested, the Medical Director shall decide whether the concept has sufficient merit to warrant further consideration. If further consideration is justified, in the sole opinion of the Medical Director, the process shall continue to Step 3. Otherwise, the suggestion and the reason for its rejection shall be documented and filed for reference, and copies sent to the person(s) initiating the suggestion and to all members of the Medical Control Board.

Step 3. Comments Obtained. Unless this process is terminated by the Medical Director pursuant to Step 2, above, preliminary comments and suggestions regarding the suggestion shall then be solicited in writing by the Medical Director as follows: Copies of the "Standard of Care Suggestion" form, along with the preliminary comments of the Medical Director shall be sent for posting to all first responder agencies, ambulance service providers, emergency communications centers, on-line medical control physicians working within the EMS System, and to the individual members of each Chapter of the EPF. Thirty days shall be allowed for submission of written comments by interested persons.

Step 4. Review and Comment by the Standards Committee. After the comments obtained during Step 3 of the process have been received and compiled, the matter shall be presented to the "Standards Committee," for review and comment. The "Standards Committee" shall consist of persons particularly interested in clinical issues, appointed by and serving at the pleasure of the Medical Director--e.g., paramedics, managers, persons involved in the quality control and in-service training programs, physicians and nurses. All related documentation shall be provided to Standards Committee members at least 30 days in advance of its scheduled review meeting, and the originator(s) of the suggestion shall be invited to present the suggestion to the Standards Committee in person. Before rendering a recommendation, the Standards Committee may determine that additional information is needed before a recommendation can be responsibly made. If the Medical Director agrees, additional information shall be obtained, such as: a more extensive review of the literature; inquiries regarding the use of the proposed standard in other EMS systems (by telephone, in writing, or by site-visit observation); demonstration by a product manufacturer; or direct examination of a purchased sample product. Taking into consideration the Standards Committee's findings, the Medical Director shall then decide whether the process shall be terminated or continued to Step 5, below.

Step 5. Financial Impact Statement. If the Medical Director finds that the suggestion merits further consideration, the suggestion shall be submitted to the Executive Director of EMSA, who shall compile a "Financial Impact Statement" estimating the marginal costs (both initial and on-going) of implementing the proposed policy change. Every provider organization whose financial obligations would be affected by the proposed policy change shall be contacted by EMSA and asked to supply a financial impact estimate (with supporting documentation and rationale). In addition to cost estimates, the "Financial Impact Statement" shall also include a summary of the short-term and long-term impact of the proposed policy change upon ambulance rates and/or subsidy requirements, and the Executive Director's official comments regarding economic aspects of the proposed change.

Step 6. Presentation to the Medical Control Board. When the previous five steps have been completed, and the exact language of the proposed amendment to the System Standard of Care has been developed, the suggestion shall be

presented to the Medical Control Board. Following the Medical Director's presentation of the suggested changes, EMSA's Executive Director shall present the "Financial Impact Statement", and all related documentation, to all provider organizations described above in Step 5, and to the Medical Control Board members at least 30 days in advance of the scheduled meeting at which any decision may be made. Unless additional information is required by the Medical Control Board before voting on the matter, the Medical Control Board shall then vote to determine whether the proposed policy change shall be adopted or rejected. The policy change may be adopted for general implementation (i.e., system wide), or on a pilot-project basis (i.e., a short-term test limited to selected personnel). If the policy change is adopted on a pilot-project basis, upon completion of the pilot project, the results shall be reviewed by the Standards Committee and by the Medical Control Board prior to deciding upon general implementation.

Step 7. Joint Approval By Medical Control Board and EMSA. In cases where implementation of such a change would, in the opinion of EMSA's Executive Director, necessitate substantial unplanned expenditures by ambulance service providers, or an increase in local tax subsidies to first responder agencies, such change shall be subject to joint approval by the Medical Control Board and the EMSA Board of Trustees prior to implementation.

Step 8. Amendment. The amendment to the System Standard of Care shall be submitted for final determination to the governing bodies of EMSA's Beneficiary Jurisdictions (i.e, Tulsa and Oklahoma City), and the proposed amendment shall be rejected unless approved by resolution of both such governing bodies.

Step 9. Filing with Non-Beneficiary Member Jurisdictions. Approved changes to the System Standard of Care shall be submitted for receipt and filing with the clerk of each Non-Beneficiary Member Jurisdiction of this Agreement.

D. Waiver of System Standard of Care Change Process Due to an Emergency.

1. "Emergency" as used in this section shall be limited to conditions resulting from a sudden unexpected happening or unforeseen occurrence or condition and situation wherein the public health, safety, or welfare is endangered.

2. The provisions of this section with reference to changes in the System Standard of Care (C, above) shall not apply whenever the Medical Director recommends to the EMSA Board of Trustees and the EMSA Board of Trustees declares by a two-thirds (2/3) vote of all of its members that an emergency exists. The Medical Director shall then proceed to investigate and prepare a recommendation for the EMSA Board of Trustees to supplement and amend the changes in the System Standard of Care due to the emergency.

3. This emergency amendment to the System Standard of Care shall be subject to ratification by the governing bodies of the Beneficiary Member Jurisdictions and shall be filed as provided in Step 9.

E. To design and conduct an on-going program of medical quality assurance capable of ensuring that all components of the EMS System, as defined herein, are functioning in conformance with the then-current System Standard of Care. In this regard, the Operations Contractor and such other ambulance service providers as may then be serving as components of the EMS System shall be subjected to identical standards of licensure, performance, reporting, and monitoring, except that the Operations Contractor's permit shall be valid solely in regard to services rendered in the Operations Contractor's capacity as subcontractor to EMSA, and under EMSA's state EMS license.

F. To develop and administer written and practical tests for purposes of certification of EMS personnel by the Medical Control Board, in accordance with the then-current System Standard of Care. Personnel subject to such certification requirements shall include:

1. Persons receiving telephone requests for ambulance services excluding 911 "complaint takers" who transfer such calls to an EMS Control Center, as defined in the Uniform Ordinance for Emergency Medical Services (Exhibit A);
2. First Responders;
3. Ambulance Personnel, and;
4. On-line Medical Control Physicians.

G. To develop standards applicable to vehicles and on-board equipment used in the delivery of first responder services and ambulance services within the Regulated

Service Area, as regulated pursuant to the Uniform Ordinance for Emergency Medical Services (Exhibit A).

H. To develop rules for fair hearing for any proposed denial, suspension or revocation of the permit of either an applicant, a permitted provider or a certified EMS personnel operating within the Regulated Service Area which such standards shall not be less than those standards contained in the Health Care Quality Improvement Act of 1986, 42 U.S.C. 11112, or less than any standards contained in applicable Oklahoma Statutes or applicable Oklahoma case law. Such procedures in any event, shall contain at least the following:

1) Written notice from the Medical Director of the charges pending against the provider or EMS personnel whose license or certification may be suspended or revoked;

2) A right to an appeal, requested in writing within 30 days, of any adverse action by the Medical Director to the Medical Control Board;

3) The right to a de novo hearing on any adverse action by the Medical Control Board conducted by an impartial and independent hearing officer, including a right to cross-examine witnesses, and to present witnesses and evidence on the person's own benefit, provided such hearing is requested in writing within 30 days;

4) A right to an appeal, of any adverse action by the Hearing Officer to the governing body of the Beneficiary Jurisdiction, selected by the provider or EMS personnel whose license may be suspended or revoked.

I. To employ an independent, impartial Hearing Officer to conduct any Hearing necessitated by a proposed suspension or revocation of a permit;

J. To monitor and enforce response time standards and compliance therewith by EMSA's contracted operator, and by any other ambulance service provider licensed pursuant to the Uniform Ordinance for Emergency Medical Services (Exhibit A);

K. To administer the process governing the review of applications for permits to provide emergency ambulance services, as prescribed in the Uniform Ordinance for Emergency Medical Services (Exhibit A);

L. To recommend to the Licensing Officer the issuance or denial of a permit as defined in the Uniform Ordinance for Emergency Medical Services.

M. To approve an annual budget, and to periodically approve expenditures from the Quality Assurance Fund as defined in Section 16, below;

14. Medical Director. The Medical Director shall be selected by, directed by, and shall serve at the pleasure of the Medical Control Board. The Medical Director shall be Board-Certified by the American College of Emergency Physicians. The Medical Director shall have the following duties:

A. To develop and recommend an appropriate System Standard of Care to be adopted as provided in this Agreement;

B. To administer the testing and certification of EMS personnel, and to establish and promulgate written regulations in connection therewith, subject to approval by the Medical Control Board;

C. To administer the licensing of all vehicles, persons and organizations who are, or seek to become, permitted providers of emergency medical services within the Regulated Service Area, as defined in the Uniform Ordinance for Emergency Medical Services (Exhibit A), in accordance with procedures approved by the Medical Control Board, and to recommend issuance or denial of permits, as defined in the Uniform Ordinance for Emergency Medical Services, to the Licensing Officer;

D. To initiate the suspension or revocation of any permitted vehicle, provider or EMS person;

E. To regulate on-line medical control in accordance with protocols and regulations established by the Medical Control Board;

F. No less frequently than one time every three months, to report on the clinical aspects of the quality of care and on the response time performance being provided by EMSA's operations contractor to the EMSA Board of Trustees, such report to be relied upon by EMSA in carrying out is contract-management role as defined in the Amended and Restated Trust Indenture (Exhibit B);

G. Once each year to report to the governing body of each member jurisdiction of this Agreement, in writing, on the quality of care and response time performance being provided by all components of the EMS System in each member jurisdiction;

H. To monitor all aspects of system performance, including clinical quality of care and verification of response time performance reported by first responders and ambulance service providers;

I. To attend meetings of the Trustees of EMSA, and of the Medical Control Board, and of the two chapters of the EPF, and to represent the EMS System at appropriate regional and national EMS-related meetings, seminars, and conferences in order to stay abreast of developments in emergency medical care (e.g., ACEP and NAEMSP conference and workshops).

J. To make final determinations regarding requests by EMSA's Operations Contractor and all other permitted ambulance providers for relief from late run deductions, in accordance with applicable provisions for such relief defined in the Operations Contract;

K. To recruit and hire appropriate personnel to assist in carrying out the duties and responsibilities of the Medical Director, subject to budget approval by the Medical Control Board, and availability of funds, as determined by the Quality Assurance Fund Administrator, as defined in Paragraph 16 below;

L. The Medical Director shall annually recommend to the Medical Control Board a budget for the operation of the EPF and the Medical Control Board, for approval and adoption by the Medical Control Board, subject to approval by the EMSA Board of Trustees in regard to funding availability, cash flow requirements, and the applicability of the proposed expenditures to the purposes and restrictions set forth herein and in the Uniform Ordinance for Emergency Medical Services (Exhibit A).

M. To inspect the standards and operations of ambulance service providers serving neighboring jurisdictions outside the Regulated Service Area for purposes of determining the eligibility of such providers to serve as mutual aid providers, as defined in the Uniform Ordinance for Emergency Medical Services (Exhibit A).

N. To conduct EMS-related research projects, to seek outside funding for such purposes, and to periodically publish in EMS-related journals and trade publications so as to enable the EMS System to be a visible and active participant in the advancement of the body of knowledge available throughout the EMS industry.

15. Medical Director -- Responsible Solely to Medical Control Board; Employed by EMSA. It is recognized that the Medical Director shall be approved by, directed by, and serve solely at the pleasure of the Medical Control Board; and that neither the Trustees nor the Executive Director of EMSA shall have any right or authority to discipline, direct, or terminate the Medical Director or his staff. However, for administrative convenience and efficiency, the salaries of the Medical Director and his staff shall be paid by EMSA from the Quality Assurance Fund, and for purposes of Federal and state employment law, and health insurance purposes, the Medical Director and his staff shall be considered employees of EMSA.

16. Quality Assurance Fund. The Trustees of EMSA, acting through its Executive Director, shall establish and administer a Quality Assurance Fund:

A. As provided for in the Uniform Ordinance for Emergency Medical Services (Exhibit A), the Quality Assurance Fund shall be financed by a $3 per transport service charge for each transport by an ambulance service provider, as defined herein, originating within the Regulated Service Areas; said $3 charge shall increase annually at the same percentage as any increase in the Consumer Price Index;

B. The Quality Assurance Fund shall be administered by the Quality Assurance Fund Administrator, who shall be the Executive Director of EMSA;

C. The Quality Assurance Fund shall be used exclusively for the payment of salaries, fringe benefits, and other related payroll expenses of the Medical Director and his assistants; for research and development activities approved by the Medical Control Board, which are intended to develop optimal quality of care provided by the EMS

System; to pay all other expenses reasonably incurred in establishing and monitoring the quality of emergency medical care delivered by the EMS system; and to have or hold any real or personal property reasonably necessary to accomplish the purposes set forth herein.

17. Termination. Each member jurisdiction's participation in this Agreement may be separately terminated upon 180 days advance notice. Such termination shall render that jurisdiction ineligible to qualify as a Non-Beneficiary Member Jurisdiction, as defined by the Amended and Restated Trust Indenture (Exhibit b), and ineligible for distribution of any portion of the Quality Assurance Fund. However, in the event this Agreement is terminated simultaneously by all then-remaining member jurisdictions, and any money remains in the Quality Assurance Fund, all such money shall be distributed, pro rata, based upon the number of transports originating within each member-jurisdiction, within the immediately preceding twelve month period, to the governing body of each member jurisdiction.

18. Signatures. The Cities of Tulsa and Oklahoma City are the initial signatories to this EMS Interlocal Cooperation Agreement, and recognize that additional jurisdictions may join with Oklahoma City and Tulsa in this EMS Interlocal Cooperation Agreement. Provided such newly added entities shall meet the Requirements for Membership, approved by the governing body of that entity, shall automatically entitle that entity to the benefits and responsibilities of membership in this EMS Interlocal Cooperative.

IN WITNESS WHEREOF, the parties have hereunto set their hands and seals this 29th day of May, 1990.

Paul Walters
MAYOR

ATTEST:

City ~~Auditor~~ Clerk

APPROVED:

City Attorney