EMS- An overview

Make EMS Essential

- ✓ **A Historical Timeline of EMS in Wapello County**
- ✓ **A picture of what the public demands of local EMS**
- ✓ **EMS System Standards- Our yardstick for improvement**
- ✓ **EMS Essential Service Resolution (update)**
- ✓ **EMS Advisory Council recommendation and sample tasks**

WAPELLO COUNTY
O.R.M.I.C.S. • Ottumwa • Wapello County Rural • Eldon • Agency • Blakesburg
EMS ASSOCIATION

Brief History Timeline of EMS in Wapello County

1940's

Funeral homes provide transport as a service.

1942, February: "Defense Ambulance Fund" fundraiser was a basketball game with Harlem Globetrotters. Goal to raise $1200 for purchase of an ambulance by the Civil Defense Committee.

1950's

1952: **Ottumwa Fire Department begins 24-hour ambulance service**. Ambulance provided by public donations and there was no fee for service.

1952, January: Fewer fires but Ambulance busier. 417 fire calls, 335 ambulance calls.

1953, July: Fire department questions the need of buying an ambulance. Four firemen laid off. City funds $7800 for a new ambulance to replace an old one from revolving fund. Talk of placing old ambulance on south side. Discussion on raising money with subscriptions.

1953, November: Money made available to purchase new ambulance. Money comes from public safety fund to reimburse revolving fund. $1200 in donations from Willing Circle of King's Daughters. Subscriptions not successful.

1955, December: Ambulance crash, taken out of service. New ambulance in service for one month involved in crash. Reliance on private services.

1960's

1962: City begins charging $8 per trip.

1966: City increases ambulance fee to $12 per trip. Hospitals handle billing. Follow-up collection letters issued by city clerk's office.

1966: President Johnson receives report "Accidental Death and Disability: The Neglected Disease of Modern Society", later known as the "EMS White Paper". Report revealed in 1965 alone, vehicle accidents killed more Americans than were lost in the Korean War. This led to standardization of emergency training which led to the first nationally recognized curriculum for EMS- emergency medical technician-ambulance (EMT-A). Many consider this document the birth of modern EMS.

1967, June: Ottumwa Fire discovers it's expensive to run an ambulance service. Fire Chief Smith wants rid of responsibility of ambulance. City at max levy. 6 firemen salaries attributed to ambulance. Pension costs soaring due to firemen retiring with back injuries during working ambulance calls.

1967, August: Legality of charging for ambulance service, questioned. AG opinion: a county hospital may subsidize a private funeral home to provide ambulance service for the hospital but could not subsidize ambulance service to hospital other than a county hospital.

1967, August: Ambulance fee study. U of I Bureau of Police Science studying a state of crisis in emergency ambulance service. Many towns and cities police and fire picking up service because many funeral homes in Iowa are ceasing service due to new federal minimum wage for drivers.

Brief History Timeline of EMS in Wapello County

1970's

1970, California Governor Ronald Reagan signed into law the Wedworth-Townsend Paramedic Act. This law created conditions for the establishment of the first accredited paramedic training program in the U.S.

1972, TV series "Emergency" aired which mirrored the LA County Fire's paramedic program. This show portrayed paramedics providing care never seen before to the nation. Johnny and Roy set a standard expectation for the public and inspired many people to become providers that work in EMS today.

1973, June: **Funeral homes cease to provide ambulance service.** Four local funeral homes informed County Supervisors they would cease ambulance service on December 31st at midnight. Funeral homes had been handling transfers from nursing homes to hospital.

1973, EMS Systems Act of 1973 established NHTSA (under DOT) as lead agency to develop EMS systems and provided funding for 300 systems nationwide. NHTSA encouraged state level involvement in developing trauma systems.

1974, March: Ottumwa looks for ways to improve ambulance service. City compared notes with Marshalltown. Ottumwa has one emergency unit based in the fire department and two non-emergency units based in health dept. No emergency service is provided to surrounding communities or rural.
1974, April: Ambulance plan revealed. Ottumwa Fire Department will operate an emergency ambulance only and only in the city limits and a section of highway outside Ottumwa. If fire department is busy, police dept. must respond with the ambulance. City will no longer provide non-emergency service and give ambulance to hospital for that service. Transfers will be driven by city personnel but attended by hospital personnel.

1974, April. Eldon Area Ambulance Service fundraises for an ambulance.

1974, June: County takes over ambulance service from fire department. **Wapello County Ambulance Service begins operations June 24, 1974**. Prior to that date only non-emergent transport service has been provided by the service in the county. The new service will respond to all calls anywhere in the county. Public is to call 682-8585. 12 members have been undergoing EMTA training at St. Joseph Hospital- the ambulance base.

1974, August: New ambulance pact between city and county. Under the agreement, the city will make its ambulance at Central Fire available for emergency service in the county in the three city-county ambulances are tied up. Discussions under way with surrounding towns for back-up service. Should ambulance show a loss, city and county would share in making up the deficit.

1975, April: New ambulance a worthy cause to raise money. Fundraising drive to raise $17,500 to purchase the ambulance from the show "Emergency". Neither city or county has a capital replacement fund. Current ambulances do not have heat or air conditioning.

1975, June: Need for a new technologically modern ambulance. Struggles with ambulances breaking down and no funds to replace. Federal Revenue Sharing funds were tapped to start the service. New ambulances cost $17,500. Appeal to the public for fundraising. Union Bank managing the Ambulance Fund.

Brief History Timeline of EMS in Wapello County

1975, July: Purchase of new ambulance. Fundraiser successful. New Dodge Maxi-van purchased for $14,359. Replaces two units: 1968 Cadillac and 1962 Chevrolet. Service retains a 1971 Ford and 1969 Pontiac.

1978, February: Eldon hosts a meeting at their school with representatives from Wellman to discuss their successful ambulance project.

1978, August: Ambulance breaks down while transporting patient to Iowa City. Service director reports issues with constant repairs. Cost of new ambulance between $20,000 - $24,000. City and County contribute one quarter of service's annual budget which was $170,000 for FY78. Receipts accounted for half of that.

1979, February: County Supervisors discuss moving administrative jurisdiction to city since they have most of the calls. Ottumwa has 26,000 of the county's 40,000 people. Costs are currently shared 50-50 but supervisors feel this isn't a fair share with a larger interest being in the city.

1979, February: Losing money. City accuses County of trying to dump ambulance service to city. Ambulance service receives $75,000 from local subsidy.

1980's

1980, February: Headline: "County wants out of ambulance service". Ambulance service offered to the two hospitals by county. Ottumwa Hospital would consider both joint and single ownership. Hospital Administrator said "We have a deep commitment to emergency services". Ambulance fee is $65 per run. Medicare and Medicaid pays 80% of allowable charges- $45 for emergency and $40 for non-emergency. Ambulance budget for FY80 $243,000. $100,000 to be collected from patient fees.

1980. April. State Representative Gettings proposed a bill to allow counties that don't operate hospitals to levy .27 cent per 1,000.

1980, April: St. Joseph Hospital proposes hospitals, doctor's offices, nursing homes pay a fee to support ambulances. Ottumwa Hospital has already proposed building ambulance facilities on their grounds and utilize the crew in hospital when not on runs and reimburse the county for that time. FY 81 ambulance budget was $304,800 with city and county each contributing $90,000 which still leaves $4,000 deficit.

1980, July: Ambulance funding a problem. City and County contributions increase from $48,000 to $90,000. Parks Commissioner Parker said city would have to lay off three positions from police or fire or not fill retirements.

1980, August: Article "Ambulance attendants get sophisticated training". There are different levels of advanced medical training for EMTs now from EMT1 to Paramedic. Ambulance service averages 8 calls per day. 80% of calls involve elderly with heart or respiratory ailments while others fall and injure themselves. The cost to convert the service from a basic EMT service to Paramedic may cost $20,000 for equipment and supplies, not including ambulances.

1980, State legislation passed bill that takes effect Jan. 1981 allowing counties to vote on an EMS levy for .27 cents per thousand.

1980, September: New ambulance tax levy question discussed. New tax could generate $96,000. County has been relying on federal revenue sharing funds to support ambulance.

Brief History Timeline of EMS in Wapello County

1980, September: Supervisors place tax levy on November ballot.

1980, November: Ambulance tax levy fails at the polls by 119 votes. (so does the hotel-motel tax).

1980, November: Ambulance fate may be up to Congress. The US Congress deciding if they will continue the federal revenue sharing program. The county receives $341,000 from this program which their $90,000 share comes from.

1980, November: Ambulance staffing challenges. Loss of "EMT-1" designation means loss of capability. EMT's fired for misconduct. EMT-1 is a trauma designation, EMT-2 is a medical designation.

1980, December: St. Joseph and Ottumwa Hospital work out a plan to move ambulance management to Ottumwa Hospital.

1981, January: Jim Ragland, backed by St. Joseph Hospital pursues setting up a city 911 phone number. Phone company says equipment costs $7,000 to $9,000. System would cost city an extra $150 per month. Hospital waives ambulance bay rent fee of $200 in exchange for backing of the program. Hospital pays for the 911 equipment. New 911 emergency number to be published in the new directories in May 1981.

1981, April: County surrenders ownership right and authority to city so city can negotiate with hospital to take over the service. County still agrees to help purchase new ambulances needed by hospital. Ambulances to be owned by city and leased to the hospital.

1981, April: County gets out of the ambulance business and gives official blessing to Ottumwa Hospital's plan to provide ambulance service beginning July 1. Supervisors terminate their 7 year agreement with the city, sells Wapello County ambulances to city for $1. County agrees to pay half cost of three new ambulances. Ottumwa Hospital asks for three year agreement with city and county to subsidize operation totaling $152,000 for the purchase of ambulances. Ottumwa Hospital's offer to take over operations includes upgrading the service to paramedic level.

1981, May: Amended contract with hospital was approved with concerns on how the hospital was going to use the money from city and county. Hospital asked for original language that specifically designated ambulances to be changed to include equipment for the ambulances.

1981, July 1. **Ottumwa Regional Mobile Intensive Care Services (ORMICS) begins county-wide service** with a three year agreement that includes a public subsidy of $152,000 to purchase ambulances and equipment with option to cease operations with a six-month notice. By end of 1981, service has 11 full-time paramedics and five EMTs.

1981, December: Ambulance service and fire department agree to cross-train to improve skills and service.

1982, January: Ambulance service level increased when a paramedic is added.

1984, January: ORMICS makes request that city and county continue subsidies. Asks city and county for $33,250 each. Request is based on equipment replacement costs. 1983 contribution was $17,500 each, which was the last year of the agreement. Tax discussion continues.

Brief History Timeline of EMS in Wapello County

1984, January: Hospital proposes public subsidies continue through 1988 when $79,000 would be given. Average ORMICS bill is $136. Basic rate in Ottumwa is $85 plus $3 per mile one way, supplies and cardiac monitor extra.

1984, March: Wapello County Supervisors committed to a $99,000 subsidy over the next three years. This leaves a deficit of $20,000. City of Ottumwa said they can provide no funds. Rate structures will be revised to make up the deficit.

1985, February: ORMICS needs $23,000 to replace a worn out ambulance. Ambulance service answered 2,740 calls last year, 1,355 in the city, 8% or 285 calls were in the county. The county will give the ambulance service $30,000 this year and $33,000 and $36,000 the next two years. Ambulance board members encouraged City of Ottumwa to pay their "fair share". Council approved a "token" amount of $3,000.

1985, March: President Reagan wants to eliminate the Federal Revenue Sharing program which Wapello County uses to subsidize ORMICS. The county has committed to $33,000 for FY86 and $36,000 for FY87. This could create issues if the program is eliminated.

1987, February: Southern Iowa Counties having a hard time funding ambulance service.

1988, August. The Wapello County Emergency Medical Services Association is formed to promote EMS, be a channel of communication between local providers and governmental and business, organizations and groups concerned with the delivery of emergency medical care, to promote EMS education, to promote a high ethical standard for EMS, to select projects funded by various grants and other funding.

1989, June: Sunnyslope closes so no tax levy ability. Sunnyslope trustees denied a property tax levy request last fall. Only a county hospital can levy for ambulance. Ambulance fee increased from $85 to $100. Federal Revenue Sharing funds ended in 1987 that allowed subsidies which went for equipment.

1990's

1990, September: Agency's First Responders helping with responses. Service started four years ago.

1994, November: ORMICS is named Paramedic Service of the Year by the Iowa EMS Association and National Paramedic Service of the Year by the National Association of EMTs.

1995, June: Chillicothe First Responders formed to serve Cass & Richland Townships, Cities of Chillicothe & Kirkville.

December, 1998: Ottumwa Regional Health Foundation dedicates a new ambulance with proceeds from Great Southeast Iowa Duck Race and Swift water Festival. An old ORMICS ambulance will be given to the Eldon community. The old Eldon ambulance will be given to the Ottumwa Rotary Club to be sent to Central America.

2000's

2000, July: ORMICS fund raiser (Duck Race). ORMICS receives no funding from city, county or tax levy. ORMICS has staff of 24 paramedics. Fundraiser to help purchase a new ambulance that costs $86,668.

2002, January: Ottumwa Fire Department raising money to buy defibrillators and other equipment to be "compatible" with ORMICS.

Brief History Timeline of EMS in Wapello County

2002, January: 20 Ottumwa Fire Fighters training to become medical first responders to assist ORMICS. Buying 3 defibrillators.

2002, February: ORMICS welcomes Ottumwa Fire Medical First Responders Program.

2002, June: Ottumwa Fire to focus their first responder program on south side of Ottumwa.

2003, April: Wapello County EMS Assn. working on training opportunities, push for EMD and seeking to work with 911 Board, working on a community trauma education program, Assn. seeks greater community involvement in EMS.

2003, August: Struggling to keep ambulance service in Blakesburg.

2005, March: Eddyville Fire Department dropping ambulance service.

2009, February: Eldon ambulance ends transport service.

2010: State of Iowa develops "EMS System Standards" and provides a scoring rubric to local partners.

2010, March: Ottumwa Regional Health Center sells to RegionalCare, a for-profit company.

2012: Wapello County EMS Association conducts public meeting of stakeholders to review System Standards.

2019: Wapello County Public Health decertifies Medicare/Medicaid, no longer provides in-home services.

2020: Worldwide COVID-19 pandemic. The "Great Resignation" occurs. Both dramatically affect workforces across all sectors, healthcare is especially hit hard.

2022, May: IHCC EMS Advisory Committee looking at very low enrollment numbers 3-EMT and 4-paramedic, discusses the need to do more outreach to recruit students. Group discussed a group effort to boost numbers.

2022: Wapello County EMS Association revisits System Standards, provides data to Service Area 5 Healthcare Coalition as required by the State. Becomes annual requirement with state in Service Area 5 with goals and action plans.

2022, October: IHCC EMS Advisory Committee discusses how to get EMS education into the high schools are early recruitment. Sub-committee formed to look into ways to do this.

2022: Ottumwa Regional asks local officials for financial assistance to shore up EMS services. Both staffing and equipment needs cited.

2022 & 2023: Discussions between hospital and city and county officials about support. No definitive actions taken.

2023, January: Letter to the community from CEO William Kiefer co-signed by community leaders explaining moving ORMICS from full paramedic authorization to conditional authorization. Letter explained why that was necessary and what it means.

Brief History Timeline of EMS in Wapello County

2023, May: Wapello Co. EMA in partnership with Van Buren County Hospital, Davis County Hospital, Centerville Fire & Rescue and Indian Hills Community College launch a 4-county partnership for a summer youth EMT internship program with a Future Ready Iowa Grant. This initiative seeks to get youth interested in EMS careers and help fill staffing gaps.

2023, May: IHCC EMS Advisory Committee recommends changes to the EMS program: eliminate degree requirement to speed up completion time for paramedics. EMS Advisory met with college administration to discuss concerns regarding the program and express commitment to support. Program moved to non-credit programs removing many of the common barriers for students that exist in the credit program. This makes the program shorter and more affordable.

2024, May: Indian Hills Community College in partnership with the original planning team repeats the summer youth EMT internship program with grant funding from Telligen. Planners are hopeful this will be a sustainable project and a constant feeder into the paramedic program.

2023, July: **EMA presents EMS as Essential Service Resolution to Board of Supervisors** on behalf of the Wapello County EMS Association representing all EMS services. Resolution supported but fails to move forward mainly due to other competing priorities.

2024, January. Supervisor Bryan Ziegler brings up topic of EMS. **EMA again presents EMS Essential Service discussion with Board of Supervisors**, meets with local officials and stakeholders. Wapello County EMS Association reviews draft Advisory Council list as recommendation to Board of Supervisors. EMA to take lead on Essential Service work, coordinating the next steps.

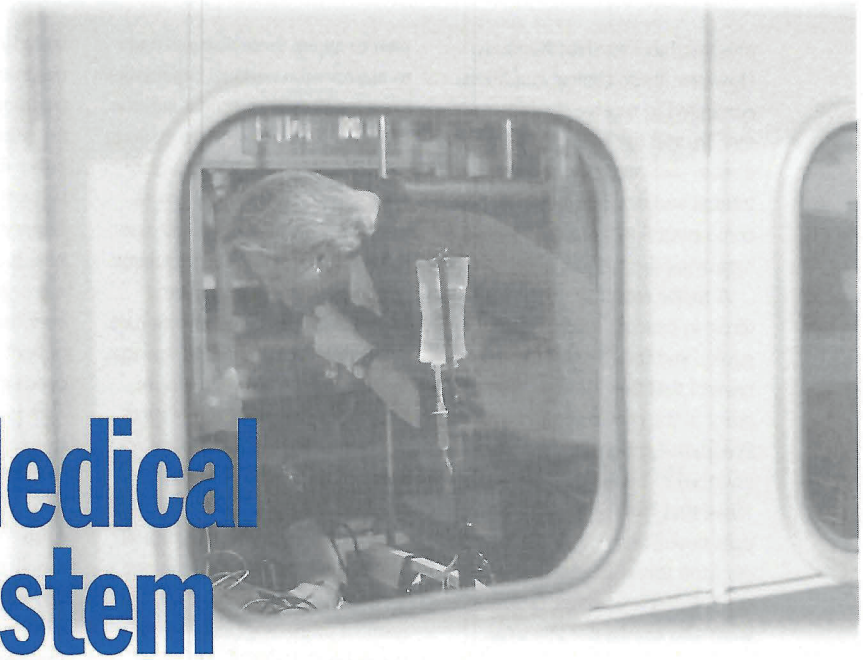
Sources:

Black font lines with month and year are found in the Ottumwa Library's online archive of the Ottumwa Courier https://ottumwa.historyarchives.online/home

Blue lines are items of national significance pulled from scholarly articles

Red lines are items of local or state significance reported by local officials

1.27.25, 2.28.25 Update



The Formation of the Emergency Medical Services System

The evolution of the emergency medical services system in the United States accelerated rapidly between 1960 and 1973 as a result of a number of medical, historical, and social forces. Current emergency medical services researchers, policy advocates, and administrators must acknowledge these forces and their limitations and work to modify the system into one that provides uniformly high-quality acute care to all patients, improves the overall public health through injury control and disease prevention programs, participates as a full partner in disease surveillance, and is prepared to address new community needs of all types. (Am J Public Health. 2006;96:414–423. doi:10.2105/AJPH.2004.048793)

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THE EVOLUTION OF THE emergency medical services (EMS) system has been a slow process. Although modern EMS initially developed during Napoleon's time to aid injured soldiers,[1] few major changes occurred in EMS until the 1960s. Between 1960 and 1973, a number of medical, historical, and social forces converged, leading to the development of a more structured EMS system in the United States. These forces have had a tremendous impact on the structure and functioning of the EMS system, resulting in profound public health implications today.

Modern EMS is considered to have started with Jean Dominique Larrey, Napoleon's chief physician, who organized a system to treat and transport injured French soldiers.[1] During the Civil War, the Union Army developed an organized system to evacuate soldiers from the field.[2] Lessons learned during the Civil War were applied as civilian EMS systems formed during the late 1800s. By 1960, a patchwork of unregulated systems had developed, with services sometimes being provided by hospitals, fire departments, volunteer groups, or undertakers. Physicians staffed some ambulances, while others had minimally trained or untrained personnel.[2] Despite the major expansion in health care facilities and the emphasis on medical specialization after World War II, the EMS system had not received much attention or innovation.[3,4]

DEVELOPMENT OF HEALTH CARE

In 1960, treating heart disease and cancer were of such interest that the need for a government-sponsored program to cure them appeared in the 1960 Democratic Party platform.[5] Following the common belief in post–World War II United States that funding for scientific and technological advances would lead to improvements in health,[4] President Kennedy empanelled a commission chaired by Michael DeBakey to improve the care of patients with heart disease and cancer. The report was to have been presented on April 17, 1961, but it was "lost" in the furor surrounding the Bay of Pigs invasion and never

designed to combat these conditions. The concept of regionalized health care became commonly accepted in EMS. For example, taking trauma or burn patients to specialty centers became expected of EMS providers.[26] Finally, the delivery of technologically advanced intensive care to patients located throughout a region, a core role of EMS, reflected the philosophy of RMPs. Although the RMPs were later disbanded by President Nixon, their legacy for EMS is significant.

INITIAL EMS DEVELOPMENTS

Despite the lack of uniform federal legislation, regulations, or standards, and despite the absence of legislation, regulations, and standards in most states and cities, EMS was developing and providing care to patients. Most advances had occurred through interest by local physicians, hospitals, firefighters, government officials, or entrepreneurs. The result was a disorganized system of variable and sometimes poor quality care. In 1960, only 6 states had standard courses for rescuers, only 4 states regulated ambulance design specifications, and fewer than half of all EMS personnel had received even minimal training (e.g., American Red Cross first aid).[27] A survey of 900 cities in 1965 found that only 23% regulated EMS service, and only 8% reported advanced EMS medical training, such as the American Red Cross advanced first aid course.[28]

"Despite the lack of uniform federal legislation, regulations, or standards, and despite the absence of legislation, regulations, and standards in most states and cities, EMS was developing and providing care to patients."

During 1965 and 1966, a convergence of political and medical actions focused the national interest on motor vehicle crashes. In 1965, President Johnson, continuing Kennedy's interest in motor vehicle crashes, created the President's Commission on Highway Safety. The Commission's report identified the great public health burden of motor vehicle crashes and stated that a coordinated national highway safety program should be a major priority.[29] In particular, the Commission felt that the timeliness and adequacy of care of the injured patient were critical. President Johnson announced his intention to discuss highway safety in his State of the Union address and transportation message in 1966.[9,30]

Simultaneously, a report released in 1966 by the National Academy of Sciences–National Research Council was extremely critical of the emergency care system. This comprehensive report, titled "Accidental Death and Disability: The Neglected Disease of Modern Society,"[31] documented the absence of quality emergency care. Some EMS-related inadequacies included: (1) no treatment protocols; (2) few trained medical personnel; (3) inefficient transportation; (4) lack of modern communications and equipment; (5) the abdication of responsibility by political authorities; and (6) the lack of research evaluating prehospital care.[31] The recommendations of both reports were incorporated into the Highway Safety Act of 1966.[9]

The law established the cabinet-level Department of Transportation to accelerate highway traffic safety programs and improve EMS. The Act specifically provided for federal involvement to improve EMS plans, ambulance specifications, equipment standards, communications, educational requirements, staffing, and other aspects of caring for medical emergencies. Additionally, the Act allowed for penalties in the event of states' failure to follow the provisions regarding EMS.[9,32]

The legislation reflected some of the prevalent themes of the 1960s, which had also been seen in the RMPs. First, the Department of Transportation was to accomplish its EMS goals primarily through a combination of demonstration projects and matching grants. This allowed different regions to experiment with different types of EMS systems. It also made it unnecessary to create categorical federal programs that would expand the federal government and require continual funding. Second, the EMS system being developed was to be technologically advanced, with significant attention to using new technology, such as radio communication and telemetry, that would allow EMS to operate over large regions. Technologically intensive medical equipment, promoted by medical leaders, would soon follow. Finally, the EMS system was supposed to improve the transportation of patients to specialty medical centers, providing advanced care to all patients in a region and supporting the regionalization of health care encouraged by the RMPs.

The assignment of EMS responsibility to the Department of Transportation, as opposed to the Department of Health, Education, and Welfare, reflected the

of the Executive Board of the American Public Health Association during Senate testimony. Pickett stated that "the health professional has a growing major role in the development of research, education, environmental modification, and emergency care to prevent and ameliorate injury, disability, and economic loss from accidents."[40(p693)]

Proposed and promoted improvements in EMS followed this belief, as reflected in the media. The lay press reported these advances and reported many individual cases of patients being brought back to life.[1] The television show "Emergency" (1971) showed EMS personnel from the Los Angeles County Fire Department heroically responding to patients suffering from traumatic and medical injuries. The EMS staff used newly developed concepts and devices such as cardiopulmonary resuscitation, defibrillation, and intravenous medications.[41,42]

The tension between the state of the federal and local governments' limited development of EMS as a transport service and (1) the transformation of EMS into a medical service using the latest available advances; (2) the media portrayal of EMS medical care and its benefit; and (3) the failure of the federal government to use the enforcement powers in the Highway Safety Act to ensure that states meet the standards for EMS led to additional controversy and demands for legislation during the early 1970s.[25,43]

FURTHER EMS DEVELOPMENT

Although the federal government continued to view EMS as it had in the early 1960s—as a transportation agency that provided basic first aid—medical advances had revolutionized EMS. In 1972 the National Academy of Sciences–National Research Council released an analysis of the EMS system showing that the federal government, despite a stated EMS commitment, lacked a coherent policy and had failed to sufficiently advance EMS.[43]

Despite the report, the Nixon Administration's commitment to EMS continued to be disorganized and contradictory. In 1972, President Nixon stated: "By using new technologies to improve emergency care . . . we can save the lives of many. . . ."[44] Additionally, the Department of Health, Education, and Welfare funded EMS demonstration programs in 5 regions in 1972. However, by 1973, the Division of Emergency Health Services and the RMPs were being eliminated. Congressional leaders worked to correct this lack of political leadership and the division of EMS responsibilities among multiple agencies. In 1972, bills were introduced to "authorize assistance for planning, development and initial operation, research, and training projects for systems for the effective provision of health care services under emergency conditions."[45] Nixon opposed these bills, and none passed.

The Robert Wood Johnson Foundation, noting the importance of EMS,[46] announced in 1973 that it would fund 44 demonstration projects at a total cost of $15 million to have "a catalytic effect on bringing together various aspects of emergency health services."[47] The goals of the program were to develop technology, training, and interagency coordination. The program also actively recognized and supported the need for regionalization of EMS health care by encouraging cooperation between organizations that usually did not cooperate with each other. The codirector of trauma surgery at Yale University, Blair Sadler, was chosen to lead this initiative.[48]

In January 1973, Senators Cranston, Kennedy, and others reintroduced EMS legislation. Supporting arguments for the EMS Systems Development Act were made as they had been in the past. Political leaders described the crisis in public health. Senator Kennedy stated: "Nowhere is the health care crisis . . . more evident . . . than in the appalling lack of high quality emergency medical services."[25] The medical conditions used to argue for the RMP and for the Highway Safety Act of 1966 were highlighted again. It was believed that 350 000 deaths from heart disease and thousands of deaths and injuries from trauma could be eliminated with rapid, quality care.[25] The failure of previous legislation and federal policy was also highlighted to argue for this act. Data were presented showing that, despite years of work, only 7% of EMS vehicles met design standards, and 35% of EMS staff had minimally acceptable training.[25] The failure to develop regional EMS councils, quality communication, and universal access to care was also highlighted. The US EMS system was compared unfavorably with Moscow's EMS system, which provided care within 7 minutes.[25]

A number of medical leaders testified as to the importance of this legislation. Among them were representatives from the American Medical Association, American Heart Association, and the American College of Surgeons. Peter Safar, a founder of critical care medicine and EMS, described the state of EMS as a

"The important role of EMS providers in public health (beyond acute medical care) has been emphasized through a number of programs, conferences, and policy statements between the National Association for EMS Physicians, the American Public Health Association, the National Highway Traffic Safety Administration, and the Health Resources and Services Administration."

present in the United States today. Changes have occurred in the EMS system since 1973. New technologies and medications have continued to increase the level of care provided by emergency medical technicians. The federal role has been reduced significantly, to a role now primarily of technical assistance and coordination by the National Highway Traffic Safety Administration.[50] The Omnibus Budget Reconciliation Act of 1981 restructured the funding for EMS and integrated EMS programs into the Health Prevention Block Grants. This has further decentralized EMS activities and direction to each state, and has resulted in a decrease in governmental funding to EMS.[32,51] However, the fundamental themes evident during the early development of the EMS system (through 1973) continue to have a significant impact on the structure and functioning of the current EMS system.

Reducing the tremendous burden of heart disease, stroke, and trauma was a major force in the development of the EMS system. Political and medical leaders felt that, by deploying a sophisticated EMS system throughout the nation, death and disability caused by these conditions could be decreased. Without the stimulus of these common conditions to promote the need for EMS, the systems might not have developed as rapidly as they did. However, the emphasis on trauma and cardiovascular diseases has resulted in a sophisticated prehospital cardiac and trauma care system, while ignoring other significant patient populations, such as the pediatric population. Rectifying this imbalance has required additional public and private efforts, including legislation and funding to encourage research and training advancements.

Additional EMS emphasis on pediatric patients has occurred through the Emergency Medical Services for Children program, established through legislation in 1984 and supported by the US Department of Health and Human Services' Health Resources and Services Administration and the National Highway Traffic Safety Administration.[52,53] This program has trained many EMS providers how to care for children, provided services to prevent pediatric injuries, and supported pediatric EMS research. Emphasis on geriatric patients, such as that through a recent educational initiative by the American Geriatrics Society and the National Council of State EMS Training Coordinators, aims to improve the ability of EMS staff to care for older adults.[54] The important role of EMS providers in public health (beyond acute medical care) has been emphasized through a number of programs, conferences, and policy statements between the National Association for EMS Physicians, the American Public Health Association, the National Highway Traffic Safety Administration, and the Health Resources and Services Administration. One initiative was the "EMS Agenda for the Future," which presented the challenges and opportunities for the EMS system to achieve its public health potential.[55] A second was the EMS and Public Health Roundtable, which included public health and EMS leaders, such as Mohammad Akhter, MD, MPH, Quentin Young, MD, Arthur Yancey, MD, Theodore Delbridge, MD, and Robert Bass, MD. This group identified opportunities to deliver community health services through collaboration between EMS and public health professionals, and developed strategies to promote this collaboration.[55–57] These initiatives aim to integrate EMS into the public health infrastructure.

The focus on traumatic injuries and cardiovascular diseases has also shaped EMS standards, resulting in a set of standards needed for only a fraction of EMS patients. For example, one commonly accepted EMS standard is the 8-minute response time (EMS personnel must arrive at a patient within 8 minutes of the time of the call 90% of the time), which arose from the importance of providing early defibrillation.[58–60] To achieve this demanding standard, ambulances travel using lights and sirens, and large numbers of ambulances are positioned throughout each EMS region.

This rapidity of care is unneeded for most patients. Only those patients suffering out-of-hospital cardiac arrest have been shown to benefit from such rapid response (in order to defibrillate the patient).[61] There is great cost to this standard of care. A large number of paramedics are required to operate the EMS system to maintain the extremely low

having an impact in other nations, as their leaders look to the United States EMS system as a model system.[72–75] As the EMS systems evolve, knowledge of these forces and the impact they have had will be critical for health care leaders as they attempt to create a high-quality, cost-effective system that improves the overall public health.

CONCLUSIONS

The EMS system developed rapidly between 1960 and 1973 because of the convergence of historical, medical, and social forces. Although generally beneficial, these forces have resulted in an EMS system with notable limitations. EMS leaders must acknowledge these forces and limitaions as they continue to develop the system into one that provides uniformly high quality acute care to all patients, improves the overall public health through injury control and disease prevention programs, participates as a full partner in national disease surveillance, and is prepared to address evolving community needs such as terrorism preparedness, which has received so much attention since 2001.[76] ■

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This article was accepted February 10, 2005.

Acknowledgments

The author thanks Rollin J. Fairbanks and E. Brooke Lerner and Richard Blaha for reviewing the article and making extensive comments.

References

1. Eisenberg MS. *Life in the Balance: Emergency Medicine and the Quest to Reverse Death.* New York, NY: Oxford University Press; 1997.

2. Post C, Treiber M. History. In: Kuehl AE, ed. *Prehospital Systems and Medical Oversight.* 3rd ed. Dubuque, IA: Kendall/Hunt Publishing Company; 2002: 3–18.

3. Boyd DR. The conceptual development of EMS systems in the United States, Part 1. *Emerg Med Serv.* 1982;11:19–23.

4. Starr P. *The Social Transformation of American Medicine.* New York, NY: Basic Books; 1982.

5. Komaroff AL. Regional medical programs in search of a mission. *N Engl J Med.* 1974;284:758–764.

6. DeBakey M. Interview. August 17, 1991. Available at: http://rmp.nlm.nih.gov/RM/G/G/A/K/_/rmggak.html. Accessed September 26, 2003.

7. *Report to the President: A Program to Conquer Heart Disease, Cancer, and Stroke.* Washington, DC: President's Commission on Heart Disease, Cancer, and Stroke; 1964.

8. *Report of the Secretary's Advisory Committee on Traffic Safety.* Washington, DC: US Department of Health, Education, and Welfare; 1968.

9. Highway Safety Act of 1966 (PL 89–564). *Legislative History.* Washington DC: US Government Printing Office; 1967:2741–2765.

10. Heaton LD. Army medical service activities in Viet Nam. *Mil Med.* 1966;131:646.

11. Strickland SP. *The History of Regional Medical Programs.* Lanham, MD: University Press of America; 2000.

12. Egeberg R. Interview. January 1993. Available at: http://rmp.nlm.nih.gov/RM/G/G/B/E/_/rmggbe.html. Accessed October 4, 2003.

13. Committee on the Costs of Medical Care. *Medical Care of the American People.* New York, NY: Arno Press; 1972. Reprint of: Committee on the Costs of Medical Care. *Medical Care of the American People.* Chicago, IL: University of Chicago Press; 1932.

14. Heart Disease, Cancer, and Stroke Amendments of 1965 (PL 89–239). *Legislative History.* Washington, DC: US Government Printing Office; 1966.

15. Paul O. The regional medical program: The multicentral (urban) area. *Med Clin North Am.* 1970;54:29–33.

16. Castle CH. The regional medical program: the unicentral (rural) region. *Med Clin North Am.* 1970;54:19–28.

17. Marston RQ, Yordy K. A nation starts a program: regional medical programs 1965–1966. *J Med Educ.* 1967;42:17–27.

18. Sheps C. Interview. July 27, 1992. Available at: http://rmp.nlm.nih.gov/RM/G/G/B/C/_/rmggbc.html. Accessed October 4, 2003.

19. Cater D. Comprehensive health planning: I. Creative federalism. *Am J Pub Health.* 1968;58:1022–1025.

20. Chambliss CR. Regional medical programs: a new model for health care. *J Natl Med Assoc.* 1968;61:25–30.

21. Wilbur DL. Quality and availability of health care under regional medical programs. *JAMA.* 1968;203:143–147.

22. *Regional Medical Programs: Benefiting People and Implementing Local Health Services.* Boise, Idaho: Public Accountability Reporting Group; 1974.

23. Odoroff ME. Measuring progress of regional medical programs. *Am J Pub Health.* 1968;58:1051–1054.

24. *Report from: Emergency Medical Services Regional Conference: January 31–February 3, 1973.* Buffalo, NY: Lakes Area Regional Medical Program, Inc; 1973.

25. *Emergency Medical Services Systems Development Act of 1973. Hearings. 93rd Congress, 1st Session, on §504.and §654.* Washington DC: United States Congress, Senate, Committee on Labor and Public Welfare, Subcommittee on Health; 1973.

26. Edlich RF. Three giant steps toward the development of a modern emergency medical service system. *J Emerg Med.* 1991;9:61–66.

27. Kelly J. Rescue squad. *Am Herit.* 1996;47:90–100.

28. Hampton OP Jr. Present status of ambulance services in the US. *Bull Am Coll Surg.* July–August 1965:55.

29. *Health, Medical Care, and Transportation of Injured.* Washington, DC: President's Commission on Highway Safety; 1965:10–19.

30. *Public Papers of the Presidents of the United States: Lyndon B. Johnson, 1967.* Vol 1, entry 6. Washington, DC: US Government Printing Office; 1967: 3–12. Available at: http://www.lbjlib.utexas.edu/johnson/archives.hom/speeches.hom/660112.asp. Accessed September 25, 2003.

31. Committees on Trauma, Shock, and Anesthesia, Division of Medical Sciences. *Accidental Death and Disability: The Neglected Disease of Modern Society.* Washington, DC: National Academy of Sciences–National Research Council; September 1966.

32. National Committee for Injury Prevention and Control. Injury prevention: meeting the challenge. *Am J Prev Med.* 1989;5(Suppl 3):276–277.

33. *Highway Safety Program Manual: Vol 11. Emergency Medical Services.* Washington DC: United States Department of Transportation; 1969.

34. Pantridge JF, Geddes JS. A mobile intensive care unit in the management of myocardial infarction. *Lancet.* 1967;2:271–273.

35. Fee E, Brown TM. The unfulfilled promise of public health: déjà vu all over again. *Health Aff.* 2002;21:31–43.

36. Fisher L, Brown TM. Donald Budd Armstrong and W. Graham Cole: early injury control advocates. *Am J Public Health.* 2004;94:941.

37. Waller JA. Reflections on a half century of injury control. *Am J Public Health.* 1994;84:664–670.

38. Armstrong DB, Cole WG. Can child accidents be prevented in your community? *Am J Public Health.* 1949;39:585–592.

39. Haddon W Jr. On the escape of tigers: an ecologic note. *Am J Public Health.* 1970;60:2229–2234.

40. *Emergency Medical Services Systems Development Act of 1973. Hearings. 93rd Congress, 1st Session, on §504.and §654.* Washington, DC: United States Congress, Senate, Committee on Labor and Public Welfare, Subcommittee on Health; 1973:691–694.

41. *Emergency.* Available at: http://www.emergency51.com. Accessed June 1, 2004.

42. Diehl D. The EMS Program. In: Isaacs SL, Knickman JR, eds. *To Improve Health and Health Care 2000: The Robert Wood Johnson Foundation Anthology.* San Francisco, Calif: Jossey-Bass; 2000.

43. Committee on Emergency Medical Services, Division of Medical Sciences. *Roles and resources of federal agencies in support of comprehensive emergency systems.* Washington, DC: National Academy of Sciences–National Research Council; March 1972.

44. Nixon RM. *President's Message on Health Care System.* Washington, DC: US House of Representatives, 92nd Congress; March 2, 1972.

45. *Emergency Medical Services Development Act of 1972. Hearings, 92nd Congress, Second Session.* Washington, DC: US Congress, House Committee on Interstate and Foreign Commerce, Subcommittee on Public Health and Environment; 1972.

46. Isaarc SL, Sandy LG, Schroeder

Painting the picture—What our public asks of EMS

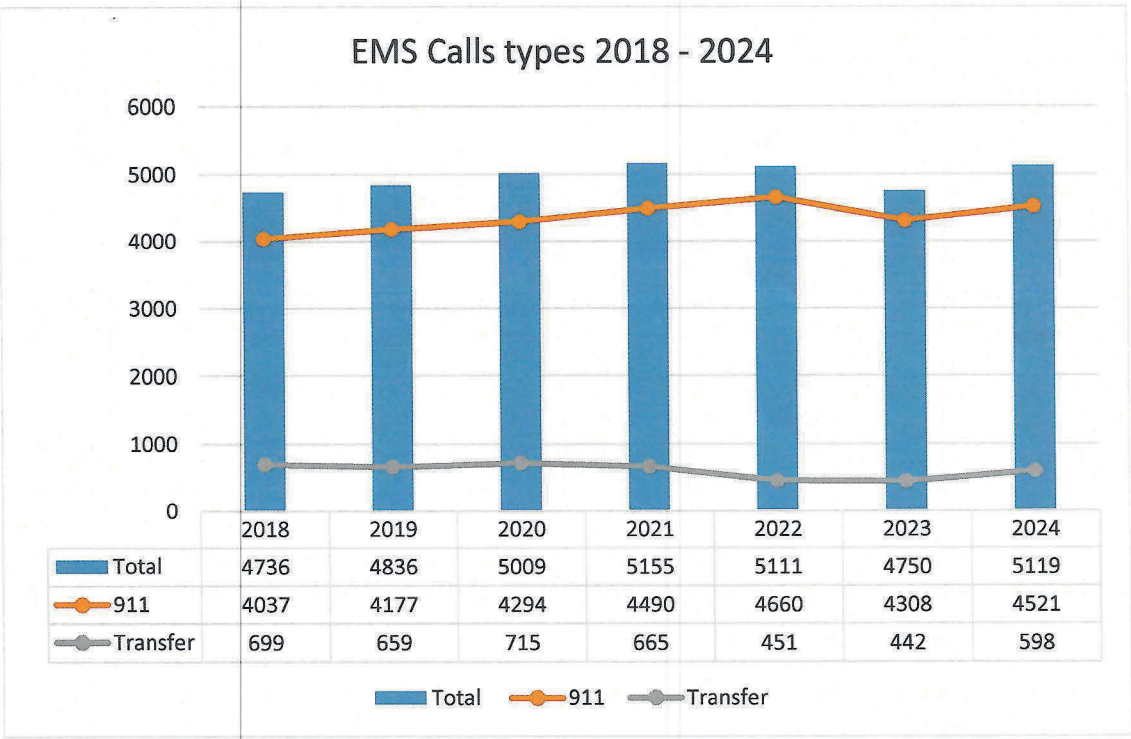
Data points

1. **Total Annual Calls^**
2. **911 vs Transfers***
3. **Runs by Chief Complaint for 2024**

^Caveat- ONE high volume caller can flux the annual numbers.
*Transfers defined as any planned movement of patients between facilities i.e. ORHC to LTC, ORHC to other hospitals such as Des Moines, Iowa City, Quincy

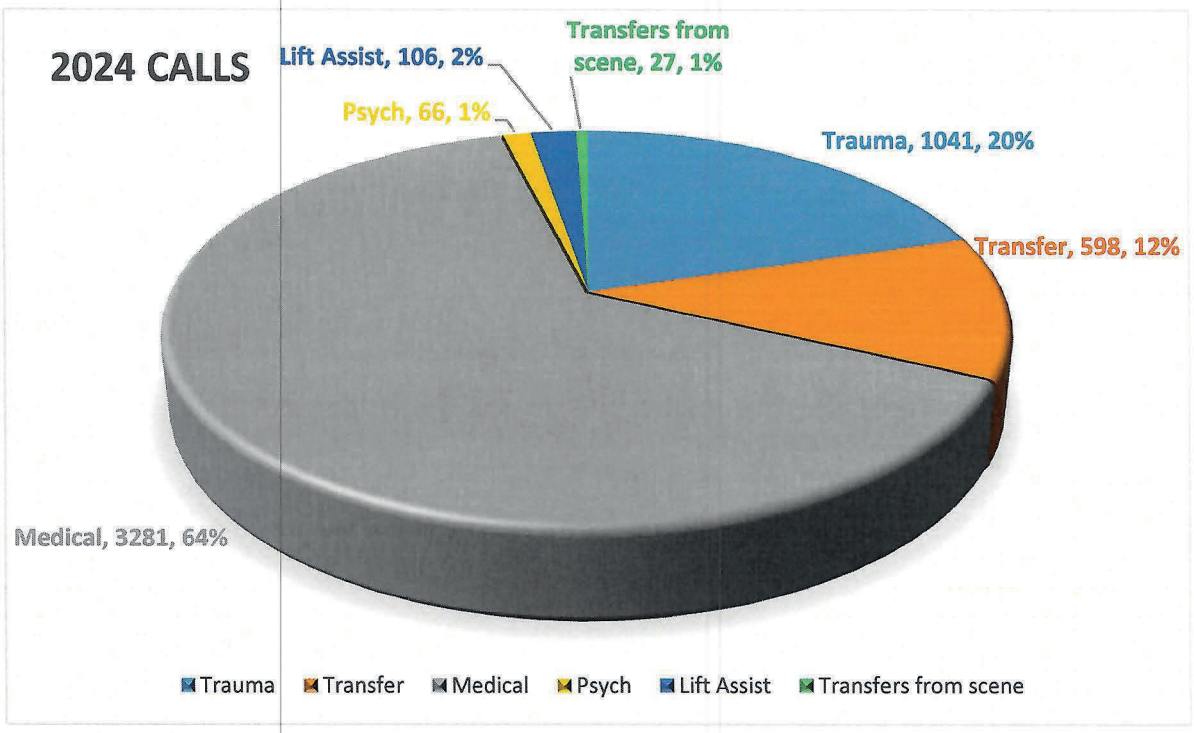
Late (October) 2024, trend of increasing number of patients being sent to ORHC from surrounding county hospitals for ICU care. ORHC reopened ICU in fall 2024. Larger hospitals full and unable to take these patients.

2022 & 2023- lower number of transfers due to contracting out this service because of low staffing numbers. Low staffing numbers addressed with TWO pay increases in Spring and Fall of 2023 which was a $7 per hour increase to starting wage. 2024- starting salaries PM-$25.89, EMT 17.16.



	2018	2019	2020	2021	2022	2023	2024
Total	4736	4836	5009	5155	5111	4750	5119
911	4037	4177	4294	4490	4660	4308	4521
Transfer	699	659	715	665	451	442	598

Painting the picture—What our public asks of EMS



IOWA EMS SYSTEM STANDARDS

"What every Iowan can expect from Emergency Medical Services"

Iowa Department of Public Health
Division of Acute Disease Prevention
Emergency Response and Environmental Health

Bureau of Emergency and Trauma Services

In 2010 the final version was released and has been well utilized for the last 7 years. Starting in 2016 a EMSAC established a System Standards Sub Committee to re-convene and update the published standards.

This subcommittee reviewed the original eight areas of EMS system development and using the same guiding principles condensed the areas to those standards that enhance systems but are not repetitive of Iowa Statute or Administrative Rule. There are over 900 authorized EMS service programs in the state of Iowa. Every one of these service programs are authorized by the state and function under operational standards dictated by administrative rule. These rules represent the baseline standard in order to protect the health of Iowans. To build EMS Systems we must strive to accomplish achievable standards above and beyond administrative rule. We must coordinate efforts at the dispatch, EMS and hospital levels in order to reduce inefficiency and redundancy in administration, training, education and overall costs of operation. We must hold the emergency response entities in our state to the utmost highest level to best serve our injured and ill.

This subcommittee worked diligently under the continued premise that an Emergency Medical Service (EMS) provides emergency medical care to individuals that experience illness or injury. Emergency medical response requires a coordinated effort that involves multiple responders and agencies working in concert to provide a seamless response to ensure that resources are available to meet the needs of the emergency. This coordinated effort represents the grass roots of system development. However, we must continue to reach for a higher standard.

Glossary of Terms

ALS - Interventions identified at the AEMT, EMT-P, or Paramedic level

AMANDA - The online registry and database for regulatory programs within the Bureau of Emergency and Trauma Services

Ambulance - As defined by rule: 641-132.1 (147A) Definitions. "Ambulance" means any privately or publicly owned ground vehicle specifically designed, modified, constructed, equipped, staffed and used regularly to transport the sick, injured or otherwise incapacitated."

Audit - Review of a process

BLS - Interventions identified at the EMR, or EMT level

Certification - State of Iowa EMS Certification

CQI - As defined by rule: 641-132.1 (147A) Definitions. "Continuous quality improvement (CQI)" means a program that is an ongoing process to monitor standards at all EMS operational levels including the structure, process, and outcomes of the patient care event." This can change to fit the system.

Credentialing - The process for ensuring knowledge, skills and ability to participate within the system.

EMD (Emergency Medical Dispatch) - "Emergency Medical Dispatching" shall mean the reception, evaluation, processing, provision of dispatch life support, management of requests for emergency medical assistance, and participation in ongoing evaluation and improvement of the emergency medical dispatch process. This process includes identifying the nature of the request, prioritizing the severity of the request, dispatching the necessary resources, providing medical aid and safety instructions to the callers and coordinating the responding resources as needed but does not include call routing per se.

EMS - As defined by rule: 641-132.1 (147A) Definitions. "Emergency medical services" or "EMS" means an integrated medical care delivery system to provide emergency and non-emergency medical care at the scene or during out-of-hospital patient transportation in an ambulance."

EMS System - means an integrated medical care delivery system to provide emergency and non-emergency medical care at the scene or during out-of-hospital patient transportation in an ambulance." The system shall be no smaller than a county.

ESF - Emergency Support Function

Iowa EMS System Standards

System Organization and Management

1.01 System Administration: EMS System Structure; Organization; Mission

MINIMUM STANDARDS:

The EMS system shall have a county wide written vision and mission statement.

The EMS system shall have an advisory group with representation from one member of the County Board of Supervisors, one member from each of the EMS services in the county wide EMS System, and one EMS medical director (designated as the county wide EMS System medical director).

The EMS System advisory group shall annually:

1. Assess each of the Iowa EMS System Minimum Standards and make provisions accordingly for emergency medical services treatment and transport within the county.
2. Submit the assessment to the Iowa Department of Public Health Bureau of Emergency and Trauma Services.
3. Complete strategic plans to assure that gaps in Iowa EMS system standards assessments are met.
4. Develop policies and procedures to implement the Iowa EMS System Standards.
5. Identify funding mechanisms that are sufficient to ensure continued operation of the EMS System and services required to meet the needs of the population.

1.02 System Administration: Public Impact

MINIMUM STANDARD:

The EMS system shall implement survey processes to obtain patient, healthcare and public input.

Staffing and Training

2.01 Staffing: Personnel

MINIMUM STANDARD:

The EMS system shall maintain up to date service rosters and assure provider certification.

The EMS System or services within the system shall have a policy regarding background checks.

The EMS system or services within the system shall notify the Bureau of Emergency and Trauma Services, as required by rule, of occurrences or potential violations that impact service license of individual EMS certification through the provided system for complaints (AMANDA)

The EMS system or services within the system shall credential personnel as per EMS certification level scope of practice and local protocol as authorized by the medical director.

The EMS System Advisory Group will assess staff numbers and staffing gaps in the system.

The EMS System Advisory Group will develop training plans for initial training to mediate staffing gaps.

The EMS System Advisory Group will develop a training plan that details anticipated trainings in the System as needed by services within the system. The plan will coordinate education and training opportunities to reduce duplication of efforts and leverage local and system funding.

2.02 Staffing: Dispatch Training

MINIMUM STANDARD:

Public safety answering point (PSAP) operators with medical dispatch responsibilities and all medical dispatch personnel (both public and private) shall be trained and/or certified using an approved program.

The EMS System medical director and/or the medical director steering committee will collaborate with county PSAP (s) to implement Emergency Medical Dispatch services for all 911 calls for medical assistance.

Communications

3.01 Communications: Plan

MINIMUM STANDARD:

The EMS system shall assess, at least annually, communications linkages (inter-operability) among providers (out of hospital and hospital) in its jurisdiction and recommend needed changes for their capability to provide service in the event of multi-casualty incidents and disasters.

The EMS system advisory group shall develop EMS communications plan for services in the system. The plan shall specify the medical communications capabilities of emergency medical transport vehicles; non-transporting agencies; and system participants.

The EMS system shall assure all emergency medical transport vehicles have the ability to communicate with a single dispatch center or disaster communications command post.

The EMS system shall have a functionally integrated dispatch with system-wide emergency management coordination, using standardized communications frequencies.

The EMS system will work to establish an emergency medical dispatch priority reference system, including systemized caller interrogation, dispatch triage policies, and pre-arrival instructions.

3.02 Communications: 911 Coordination

MINIMUM STANDARD:

The EMS system advisory group shall seek to have an active member appointed to the county 911 commission in order to participate in ongoing planning and coordination of the enhanced 9-1-1 system

3.03 Communications: Education

MINIMUM STANDARD:

The EMS system shall be involved in public education regarding system access.

4.03 Response & Transportation: Air-Medical Services

MINIMUM STANDARDS:

The EMS system shall have a process for identifying specialty air-medical transport services and shall develop policies and procedures regarding:

- Request of air-medical services
- Addressing and resolving formal complaints

Facilities/Critical Care

5.01 Facilities: Assessment of Capabilities

MINIMUM STANDARD:

The EMS system advisory group shall annually assess the capabilities of acute care facilities in its service area to include trauma level, STEMI, Stoke, OB, ortho and any other specific patient criteria.

The EMS system advisory group shall assure that services within the system have updated information regarding facility capacity.

5.02 Facilities: Trauma Care system

MINIMUM STANDARD:

The EMS system and all services within the system shall follow the Out of Hospital Trauma Triage Destination Decision Protocol.

5.03 Trauma Care Facility Verification

MINIMUM STANDARD:

The EMS system partners shall participate in the trauma verification process as available in system area.

6.03 System Evaluation: Reporting

MINIMUM STANDARD:

The EMS system shall complete an annual, report on the results of the evaluation of EMS system operations to the County Board of Supervisors.

6.04 Data Collection: Pre-hospital Record

MINIMUM STANDARD:

In accordance with IAC 641-132.8(3) a all services within a system will complete and maintain a patient care report, provide a verbal report upon delivery of a patient and shall provide the completed patient care report within 24 hours to the receiving facility

6.05 Data Collection: Data Management System

MINIMUM STANDARD:

The EMS system services shall participate in an integrated data management system that collects and submits reportable data as directed in accordance with IAC 641-132.8 (3) q that includes system response and clinical (pre-hospital, hospital and public health data.

The EMS system shall utilize the system to review reports and review outcome data.

The EMS System will participate in a minimum of one exercise per year that includes local response partners and assist in the completion and submission of an after action report improvement plan

8.02 Disaster Medical Response: Response Plans/Review

MINIMUM STANDARD:

The EMS System shall have medical response plans and procedures for disasters which shall be applicable to multi-hazard response.
a) The EMS system shall annually review and update the disaster medical response plans that are inclusive of all ESF-8 partners based on exercise lessons learned and after action improvement plans.

8.03 Disaster Medical Response: Emergency Operation Centers

MINIMUM STANDARD:

The EMS system shall be represented and participate with their local response partners in the development and exercise of a plan for activation, operation and deactivation of the emergency operation center.

8.04 Disaster Medical Response: Hazardous Materials Training

MINIMUM STANDARD:

The EMS System shall ensure all EMS providers are properly trained for response to hazardous materials awareness. The service will determine the required system role, train and equip the staff.

8.05 Disaster Medical Response: Plan Participation (ICS)

MINIMUM STANDARD:

The EMS system shall assure that services are capable of implementing all components of the National Incident Management System, including training and incident command

RESOLUTION #_____

**DECLARE EMERGENCY MEDICAL SERVICES (EMS)
TO BE AN ESSENTIAL SERVICE IN WAPELLO COUNTY,
IOWA AS AUTHORIZED BY IOWA CODE SECTION 422D.1**

WHEREAS, the Wapello County Board of Supervisors has the authority under Iowa Code 331.301(1) to "...exercise any power and perform any function it deems appropriate to protect and preserve the rights, privileges, and property of the county or of its residents, and to preserve and improve the peace, safety, health, welfare, comfort, and convenience of its residents"; and

WHEREAS, Wapello County supports EMS to its residents and seeks to provide Emergency Medical Services to all its citizens and visitors; and

WHEREAS, ensuring efficient and effective EMS coverage is essential for maintaining the health and welfare of its residents; and

WHEREAS, the Wapello County Board of Supervisors recognizes the importance of maintaining and advancing the level of care, capability, and coverage of Emergency Medical Services (EMS) in Wapello County; and

WHEREAS, on June 9, 2021, Iowa Senate File 615 was signed into law by Governor Reynolds, amending Iowa Code Section 422D.1, giving Iowa Counties the ability to declare EMS an essential service for their respective county, thereby making it possible for counties to propose additional funding sources for EMS to the county's voters at an election.

WHEREAS, Wapello County Board of Supervisors, on January 28, 2025, directed that notice of the first meeting to consider this resolution be made and any other actions be taken as necessary to proceed with the process under Iowa Code Section 422D.1 to declare EMS to be an essential county service.

NOW, THEREFORE, BE IT RESOLVED by the Wapello County Board of Supervisors, that Emergency Medical Services (EMS) is hereby declared an essential service in and for Wapello County, Iowa, and the Wapello County Board of Supervisors will exercise the necessary power and functions appropriate to preserve the health, safety, and welfare of Wapello County residents and provide for an effective and efficient Wapello County Emergency Medical Services (EMS) System that allows for quality care for the persons living, working or traveling in Wapello County, Iowa.
Exercising said necessary power and function includes, but is not limited to, the establishment of a Wapello County Emergency Medical Services Advisory Council and the proposition of a local option income surtax and/or ad valorem property tax to fund EMS to be voted upon by Wapello County voters.

NOW, BE IT FURTHER RESOLVED, that adoption of this resolution will allow:

1) The creation of a county emergency medical services system advisory council to assist in researching/assessing the service needs of the county and guide implementation of the same under Iowa Code Section 422D.1.

2) For an election to be offered for voter approval of an ad valorem property tax not to exceed seventy-five cents per one thousand dollars of assessed value and/or a local option income surtax not to exceed 1% for EMS, and

EMS Advisory Council Function and General Activities

Function

- Ensure access and quality by evaluating the structure, process, and outcome of EMS events.
- Fiscally Responsible
- Appropriate resource utilization
- Reduce the burden on the volunteer EMS provider
- Integrate EMS into the existing healthcare system
- On-going system strategic planning, implementation, and monitoring.

General Activities

- Gather and analyze EMS system information and data
- Make decisions based on facts
- Acquire an EMS system coordinator
- Set and implement goals
- Continually monitor system structure, process, and outcomes.

Often sub-committees are formed for detailed work to study emerging issues and bring suggestions for implementation back to the entire task force. Sub-committees cannot act independently as there is often overlap in tasks. For example, the medical performance committee is charged with setting minimum response time and level, but the fiscal committee will determine if the system can support the suggestions.

Medical Performance Standards:

- On and off-line medical direction
- Minimum response
- Protocols
- System CQI
- Credentialing/competency
- Documentation/Data Input
- Risk management

Human Resources

- Leadership
- Education and training
- Recruitment and retention
- Tiered response
- Non-transport or ambulance

Fiscal Management

- Accountability
- Based on performance standards
- Grant opportunities
- Equitable cost sharing
- Eliminate duplication and waste
- Allows for system growth

Health Promotion (primary and secondary)

- Injury and illness prevention
- Public information and education

"Flexible, creative thinking leads to better solutions which leads to quality."