WAPELLO COUNTY EMERGENCY MEDICAL SERVICES ADVISORY COUNCIL

Wednesday, September 2, 2026

Regular Meeting Minutes

Wapello County Emergency Management Office, 2417 Emma Street, Ottumwa, Iowa — in person with remote participation

1. Call to Order and Roll Call

Tim Richmond, Chair, called the meeting to order and conducted a roll call, with each participant stating name and agency. Participants were advised that the meeting was being recorded to assist with transcription and preparation of minutes.

Present (16): Cindy Hewitt, Preston Potts, Loren McIntosh, Athena Sears, David Cronin, Robert Vaughn, Josh Chance, Pat Short, Quincy Keck, Lori Reeves, TJ Millikin, Jean Dell, Tim Richmond, Raquel Alderman, Samantha Haney, Tom Lazio, and Scott Reeves.

2. Approval of Minutes

Two sets of minutes were presented: the notes from the Council's CAD/dispatch visit, and the official minutes of the previous regular meeting.

MOTION: Lori Reeves moved to approve both sets of minutes as presented. Quincy Keck seconded. The Chair called for a voice vote; affirmative responses were recorded and no opposition was voiced. No individual tally or abstentions were recorded. **Motion carried.**

3. Update — July 29 Plan Presentation (No Action)

The Chair reported that the plan presentation scheduled for July 29, 2026 was cancelled. A follow-on discussion took place with those who remained and produced useful feedback, and the Mayor has expressed interest in additional discussions of that type. The Council is not yet ready for a formal public presentation phase.

The Chair further reported that he invited the Ottumwa Fire Chief to present the department's report at this meeting. The Chief declined, stating he wished to wait for Ottumwa City Council direction before doing so, while expressing appreciation for the invitation.

4. Council Workbook and Planning Framework (Information)

The Chair reviewed the meeting packet and the Council workbook distributed in approximately May 2026. The workbook contains three components:

- The draft EMS operator financial analysis — an updated draft was included in the current packet; still a work in progress.
- The hub-and-spoke scope decisions worksheet — the study of four options for a hub ambulance operator, together with the ancillary "spoke" components of the EMS system around which the Council's subcommittees are organized.
- The final draft recommendation, to be developed once the supporting work is complete.

The Chair noted the Council has been working just over a year and that conditions in this space change continually, which has required repeated adjustment of the work plan.

5. EMS Ops Radio and CAD Reporting Upgrade (Information)

The Chair reported completion of a project the Council has pursued since its inception- securing our data collection and reporting process- arising from the earlier determination that ambulance response data must be recorded in dispatch, with CAD as the authoritative record:

- The 911 Board allocated $40,000 for a new repeater at the tower and a new frequency.

- A new radio at dispatch was funded through Regional Healthcare Coalition funds rather than the 911 Board.
- A new radio and roof antenna were installed at the hospital at the end of May 2026, communicating with the tower repeater.
- The upgrade increases interoperability countywide on the EMS Ops frequency.
- Effective approximately June 1, 2026, ambulances report status directly to dispatch: assigned, en route, on scene, and leaving scene / back on base.

Three months of data are now available. The Chair credited the PD Communications Division for producing the data exports used to build the reports.

6. Response-Time Report — Methodology and August Data

6.1 Core measures

- Queue — call creation to unit assigned.
- Turnout — unit assigned to en route.
- Travel — en route to on scene.
- The paramount headline measure is unit assigned to unit on scene (turnout plus travel). Measuring from call received to on scene was judged to produce misleading data.

The earlier term "dispatch delay" was removed because it wrongly implied a lag at dispatch; "turnout" is used instead.

6.2 Statistical approach

- Median describes the typical service level; the mean is distorted by single unusual calls; the 90th percentile, paired with review of the maximum and the slow-tail calls, is the more actionable benchmark for QA, standard setting, and deciding where to investigate.
- A call is flagged as unusually long relative to other calls of the same type that month, not against a fixed number. "Mild" means noticeably slower than usual for that call type; "extreme" means far slower.
- First EMS unit on scene is tracked separately from transport arrival, consistent with the new state system standards, recognizing that fire may begin patient care earlier. An earlier arbitrary ten-minute co-response metric was removed.
- Backup units are reported separately from the hub service, recognizing that geography makes flagging more likely for the outlying service.
- Two report products are produced: a public-facing aggregate report and a confidential case-level QA report used for internal root-cause follow-up.
- Geography is currently approximated as urban versus rural by dispatch center (Police Department versus Sheriff call taker). Dispatch confirmed the data can be broken out by township, and possibly by city, which the Council wishes to pursue.

6.3 August 2026 findings

- Eight calls were flagged as unusually long for the month — a workload the Council considered far more reviewable than the twenty-five produced by earlier methods.
- Peak demand remains approximately 12:00 p.m. to 3:00 p.m., consistent with the multi-year medical call hourly capacity study covering 2024, 2025, and the first half of 2026.
- Median time to first EMS unit on scene was 6 minutes 57 seconds; the 90th percentile just under 13 minutes; the average 8 minutes.
- Of the eight flagged calls, only one was attributable to a concurrent call. It was observed that the August data alone does not by itself establish the case for added resources.
- The report includes an analysis of the effect of removing the eight flagged outliers, breakdowns by call type, day of week, and hour of day.

6.4 Data quality limitations

The PD Communications Division explained that CAD entries are human-entered and timestamped when entered; times cannot be added retroactively and must instead be noted in the call notes. Where an en route time is missing but an on-scene time is entered, CAD fills the missing field with the same value.

Examples reviewed by hospital staff demonstrated the effect: one call appearing as a twenty-plus minute response was in fact a missing on-scene time on a call next door to the station; another, a 160-minute apparent delay on June 17, was a 911 hang-up on which law enforcement had to establish scene safety before EMS could be dispatched. A further flagged call was a rural response where the travel distance, not any delay, accounted for the time.

The Council agreed that every flagged call requires contextual review before it is treated as evidence of a performance failure, and that rural travel time is a service-design question rather than automatically a response failure — though it remains worth tracking to support the case for ancillary resources.

6.5 Response-time standards

The Chair reported on the white paper provided to members regarding the eight-minute benchmark. The standard originates in a November 1979 cardiac-care article and was subsequently adopted into NFPA standards; it was never established as a clinical standard. The new state EMS system standards, issued in July 2026, move toward outcome-based benchmarks set locally by call type — with different expectations for cardiac, stroke, and trauma calls than for lift assists and welfare checks. Those benchmarks have not yet been developed here and require a conversation with the Medical Director.

6.6 Member request — expected versus actual travel time

Members raised that comparing a response on the edge of town with one at the south end of the county is not a fair comparison, and asked whether an expected travel time (by distance or mapping data) could be established and actual performance measured against it, so that outliers reflect genuine delay rather than distance. The Chair indicated this is achievable by running the report by jurisdiction or township and setting a metric for each.

7. Staffing

7.1 Crew baseline

Two crews remains the minimum and the foundation of the system. The hospital reported multiple days in the past week with two crews staffed, including most of the day of the meeting, but not yet every day. The third 10:00 a.m. to 10:00 p.m. crew remains the historical and data-supported peak-demand model, originally intended to absorb interfacility transports and overflow; those positions are built and remain, but filling the two primary crews comes first. It was noted that even three crews will not eliminate simultaneous-call events.

7.2 Crew definition

Members stressed that "a staffed ambulance" must be defined explicitly, because an EMT–EMT crew is not capability-equivalent to a paramedic–EMT or paramedic–paramedic crew. The working ideal is a paramedic plus an EMT on each ambulance, which spreads paramedic coverage across units. The Council should define the standard so performance can be measured against it and accountability maintained going forward.

7.3 RN exemption pathway

- The hospital service operates as a BLS service with conditional ALS and a critical care endorsement; at minimum a BLS crew is provided, with ALS and CCP capability supplied when available.
- Selected experienced emergency and critical care nurses can be taken through paramedic-level competencies, signed off by the Medical Director, and registered with the state, after which they may function at the approved level. Exemptions do not transfer between services or counties; the local Medical Director must sign each one.
- Participation will be limited to hand-selected experienced providers, coordinated with the Medical Director and the EMS manager; new graduate nurses would not be used.
- Historically the exemption was a locally administered checkoff; as hospitals became too short-staffed to administer it, community colleges took it on, and variation across the state led the state EMS bureau to standardize. An approved RN-to-BLS curriculum now exists and an RN-to-ALS curriculum is in

development. The current rule still permits the checkoff pathway; a rule change requiring the new curricula is unlikely until the second curriculum is complete, estimated at more than a year out.

- The intent is added depth for surge coverage rather than routine staffing, and it was noted the pathway may also aid emergency department recruitment. It was also noted that it does not relieve emergency department staffing.

7.4 Staffing metrics for the monthly report

The Council agreed that response-time data alone cannot articulate the need, and that staffing must be captured monthly alongside it. The elements identified were:

- Days meeting, or falling below, the two-crew minimum, and the reason.
- Crew composition and credential level by unit.
- Call load per crew and concurrent-call exposure.
- Indicators of workload strain. Members reported that fire crews average approximately 1.9 reports per shift while medics are believed to run three to five calls per shift, with reports taking fifteen minutes to an hour each.

It was reported that ImageTrend does not assign personnel to units and therefore cannot produce daily unit-level staffing; the hospital schedules in Home Base, and the fire department sets a daily roster by officer in charge. Whether either can be used to produce the measure is to be determined.

A related discussion covered documentation burden, including dictation and AI-assisted narrative tools now available in the reporting system, and the mixed accuracy of existing voice-to-text products.

8. Interim Fire-Based Backup Ambulance Concept

Fire department representatives proposed, as a near-term measure while the countywide plan is developed, placing the department's existing ambulance in service at the south station. The department has four paramedics, raising the possibility of a conditional ALS unit depending on the crew working.

Potential value identified

- Relief of peak-demand overload and of the cumulative call and report-writing burden on hospital medics, which members identified as a driver of burnout and attrition.
- Improved south-side coverage, estimated at approximately six minutes off response time to that area.
- Fireground medical support and possible ISO staffing credit, with potential effect on insurance ratings.
- Capacity to take lower-acuity or overflow calls, preserving hospital crews for higher-acuity work, and reducing reliance on long-distance mutual aid into town.

Conditions identified before any launch

- Ottumwa City Council authorization. Fire representatives confirmed nothing can proceed until Council grants permission.
- Medical Director approval, protocols, credentialing, CQI oversight, and state transport-service authorization. Transport status changes the department's authorization and QI obligations even if the treatment protocols remain the same.
- A defined staffing model that does not rely on sustained overtime, which members agreed would burn out fire personnel in the same way.
- An equipment inventory and costed gap list, built from a base list assuming no donations, from which shared or transferred items can then be subtracted.
- A clear BLS versus ALS scope decision. ALS materially increases medication, DEA, pharmacy, monitor, and compliance requirements. It was reported that an EMS-rated cardiac monitor runs approximately $50,000 against roughly $15,000–$20,000 for the hospital equivalent, and that a BLS unit could begin with an AED rather than a high-end monitor.
- A billing and supply agreement. The transporting service is the entity that bills, so a transporting fire service would require its own billing and supply model in place of the current informal replacement arrangement.

- Involvement of the Medical Director, including whether the expanded CQI responsibility carries additional cost.
- A clear statement from fire department leadership of what the department intends and what it needs, which members noted has not yet been provided to the Council.

Practical starting point

Members identified existing AEDs, first-out bags, backboards, and stair chair capability as the low-hanging fruit from which a BLS unit could be assembled, with the hospital and other partners asked to close the remaining gaps.

COUNCIL ACTION: An interim subcommittee was proposed from the floor to develop the interim backup-ambulance proposal while the full Council continues work on the countywide system plan. The Chair and members concurred. No formal motion was offered and no vote was taken; the subcommittee was established by consensus and the Chair referenced it as established in his closing remarks.

9. Background on Prior Proposals and Process (Information)

The Chair provided background for newer members on the history of the fire-based ambulance discussion, including a prior pilot concept raised with hospital leadership that was not presented formally, the hospital's position that the financial ecosystem of the service is tenuous and cannot absorb the loss of core service volume, and a subsequent request for support that was never funded. He described a recurring mismatch between public-sector process, which requires written and actionable proposals, and corporate decision-making practice, as a significant source of the confusion between the parties, compounded by turnover among the individuals involved.

The Chair stated the Council's position that the Ottumwa City Council is unlikely to act on any fire-based service proposal until this Council confirms it is cohesive with the countywide plan, and that the Council's role is to recommend to decision-makers what resources are needed, what each party is willing to contribute, and what will ultimately be asked of taxpayers. Members noted that the tone of the current discussion — framed as supplementing rather than replacing the existing service — was a marked improvement.

10. Dispatch and Communications

10.1 Response matrix

Members raised the strain caused by dispatching every available resource to uncertain or lower-acuity calls, with units frequently turned around on arrival of the first unit. The Chair reported he proposed a response matrix approximately a year ago, and reaffirmed the position that a locally tailored, Medical Director-approved policy — built on caller intake information, dispatch intelligence, and local operational knowledge — is the appropriate remedy, weighed against the greater risks of provider burnout and unnecessary wear on apparatus. It was noted that dispatch currently must send an ambulance whenever one is requested, and that the community lacks the alternative resources (community paramedic, nurse triage line) that would allow any other disposition.

The Chair reported the Medical Director is willing to have this conversation but will not be able to attend in September; the questions will be sent to him.

10.2 Mutual aid

The Council affirmed that under the contingency plan and at the Medical Director's direction, a mutual aid request must come from the transporting EMS agency, which holds the transport agreements, rather than from personnel on scene. Members discussed a recent incident illustrating the practical difficulty when the transporting service is committed to patient care and does not hear the request. It was noted that neighboring counties increasingly cannot fill mutual aid requests either.

10.3 Fire incident command radio access

Fire representatives reported that the incident commander is issued a single portable radio and cannot leave the fireground channel to monitor EMS Ops without risking missed fireground or mayday traffic. It was noted incident command previously carried two radios. The Council identified this as a gap requiring resolution.

10.4 Unit status and location

Members discussed existing tablet-based unit location capability and the current practice of station paging rather than closest-unit dispatch, and agreed continued evaluation of unit-status and location capability is worthwhile.

10.5 Language access (information)

The PD Communications Division reported use of a third-party interpretation service and a new AI-based translation and transcription tool now in trial, at an approximate cost in the range of $27,000–$29,000. Dispatch codes have been translated into seven or eight languages, while local schools report approximately thirty-two languages present in the community.

11. Protocol Update (Information)

The EMS manager reported that the protocols he inherited as finalized were reviewed line by line and found to contain clerical errors and items requiring adjustment, some involving medications, which must go through the Medical Executive Committee. The corrected version was sent to the Medical Director for the September 4 Medical Executive Committee meeting. Approved Version 2 protocols will then be distributed to all organizations. Nearly all medications mirror current protocols with a small number of additions, and no material change is expected at the BLS level.

12. New Business — Sexual Assault Response Program (Information)

- Nine emergency department providers have completed sexual assault examiner training. Following training on September 15–16, the hospital expects nine qualified providers, with the goal of 24/7 coverage either on site or on call.
- Grant funding will be pursued for program-related needs.
- The hospital will join the regional Sexual Assault Response Team.
- Targeted training was offered to fire, EMS, volunteer services, and law enforcement covering patient interaction, what to ask and what not to ask, and limiting questioning until the sexual assault nurse assumes care at the hospital.
- The Chair offered to distribute program information to service directors and to connect the hospital with Police Department administration.

13. Assignments and Action Items

#	Responsible	Action	Target
1	**All members**	Review the August response-time report and the QA/outlier report and advise the Chair whether the report meets the Council's needs; submit comments by email, text, or phone.	Before Sept. 16
2	**Robert Vaughn (with Tim Richmond)**	Develop the staffing element of the monthly EMS report: evaluate whether ImageTrend, Home Base, or another system can produce unit-level daily staffing, and compile a three-month look-back on crew levels and crew composition.	Ongoing
3	**Josh Chance, with "David" (see Appendix B)**	Prepare the equipment/supply gap list for the fire department ambulance and a proposed staffing and compensation model that does not rely on sustained overtime.	Next meeting
4	**Samantha Haney and Robert Vaughn**	Compile the hospital-side equipment list and pricing; identify what the hospital may be able to supply or transfer versus what the fire department must purchase.	Next meeting
5	**Interim subcommittee**	Develop the interim backup-ambulance proposal (equipment, staffing, BLS/ALS scope, billing, compliance, CQI, medical control, costed request) for Council review prior to any Ottumwa City Council submission.	Ongoing

6	**Tim Richmond**	Submit to the Medical Director the questions regarding (a) a locally tailored response matrix and (b) call-type response benchmarks under the new state system standards.	Before Sept. 16
7	**Samantha Haney**	Send sexual assault response program information to the Chair for distribution to service directors; coordinate with Ottumwa Police Department administration.	After Sept. 15–16
8	**Robert Vaughn**	Distribute the approved Version 2 protocols to all organizations following Medical Executive Committee action on September 4.	After Sept. 4

14. Next Meeting

Wednesday, September 16, 2026, at the regular time and location, with the same remote connection. One member advised of a scheduling conflict. The Chair indicated notes and follow-up material would be distributed in the interim.

15. Adjournment

MOTION: There being no further business, Loren McIntosh moved to adjourn. The meeting adjourned at approximately 8:00 p.m.

Tim Richmond, Wapello County Emergency Management — Minutes presented