MINUTES
AD HOC EMERGENCY MEDICAL SERVICES (EMS) STUDY COMMITTEE
Regular Meeting
August 6, 2026 – 5:30 PM
Chippewa County Courthouse, Room 003

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1. CALL TO ORDER

Chair Guthman called the meeting to order at 5:31 PM.

2. ROLL CALL

Attendee Name	Title	Status
Pam Guthman (Chair)	County Board Supervisor	Present
Peter Gehring (Vice-Chair)	County Board Supervisor	Present
Justus Busse	Chippewa Falls Fire & EMS Battalion Chief	Present
Dan Dixon	Chippewa Falls District 5 Alderman	Present
Sandi Frion	Bloomer City Administrator	Absent
Dale Isaacs	Boyd Village Board	Present
Corey LaNou	Town of Arthur Chair	Absent
Ron Patten	EMS Association Chair	Present
Deb Semanko	Cornell City Council	Absent
Pauline Spiegel	Town of Eagle Point Supervisor	Present
Dave Staber	Lafayette Town Chair & Fire District Board	Absent
Eric Weiland	Cadott Village Board & EMS	Present
Eugene Gutsch	Wheaton EMS Director	Present

Others Present: Traci Bremness, Andy Albarado, James Small, Amber Gilles, Chief Scott Bernette (in place of Dave Staber), Jason Moses, Tammy Thom

3. MEMBERS OF THE PUBLIC WISHING TO BE HEARD

(Comments from the public will be limited to five minutes per speaker.)

No public comments were recorded.

4. CONSENT AGENDA

1. Approve the Agenda
2. Approve the Minutes of the – June 25, 2026

Motion (Gehring/Busse) to approve at 5:33PM. Motion carried 9-0.

5. REPORTS

No reports were presented.

6. BUSINESS ITEMS

1. Review of the Ad Hoc EMS Committee Report and Possible Approval for Submission to the Executive Committee
    a. Andy Albarado presented the draft EMS Committee Report.
        i. Committee members discussed:
            1. Discussion included the potential impact of funding an EMS Coordinator position on local EMS operations. Funding would support only the

coordinator position, with implementation costs remaining the responsibility of participating in EMS services.

2. Discussion between .5 and a 1.0 FTE position was discussed
3. The EMS Coordinator position would be the next step in evaluating EMS in Chippewa County
4. Discussion of potential Rural Health Transformation grant opportunity may be to fund the EMS Coordinator position for up to four years.
5. Members discussed the need for clear communication regarding expected responsibilities and benefits of the position.
6. Discussion around the fire district does have some concerns, maybe sending a letter regarding the proposal
7. Discussion that the recommendation is intended to foster collaboration and equitable EMS service throughout the county rather than replace local services.
8. Committee members discussed that they have fulfilled the charge and members stressed the importance of education and communication as the process moves forward.

Motion (Dixon/Weiland) to adopt the EMS Study Committee Report and forward it, attaching a memo, to the Executive Committee. Motion carried 9-0.

2. Review Draft EMS Coordinator Position Description
    a. Members discussed the position could support a full-time role with the amount of position responsibilities.
    b. Other members agreed that a full-time position would attract a stronger candidate and recommended hiring an external candidate to avoid perceived bias.
    c. A member expressed concern about obtaining county board and financial support
    d. Members discussed establishing an EMS Advisory Committee to provide guidance and direction for the position.
    e. Suggestion for an edit in the job description language in the Job Summary section from "ensure" to "help ensure."

Motion (Dixon/Isaacs) to approve the EMS Coordinator Position Description with the following revisions, change position status from 0.5 FTE to 1.0 FTE and revise the Job Summary to state “help ensure”. Motion Carried 8-0, with Gehring abstaining.

3. Discuss Communication with Town and Villages
    a. Members discussed strategies for sharing the EMS Study Committee Report with municipalities.
    b. Members noted that once finalized, the report will be a public document available for distribution.
    c. Discussion included distributing the report with a cover letter explaining its purpose and recommendations.

Motion (Patten/Busse) to distribute the EMS Committee Report to Towns and Villages throughout the county prior to Executive Committee review. Motion Carried 9-0.

4. Discuss and Scheduling of Next Meeting (If Necessary)
    a. No additional meetings will be scheduled unless requested by the Executive Committee.

7. AGENDA ITEMS FOR FUTURE CONSIDERATION

None identified.

8. ADJOURN

Motion (Weiland/ Patten) to adjourn at 6:43 PM. Motion carried 9-0.

The **mission** of this committee is to:

A. Assess the strengths and challenges of Chippewa County EMS services.
B. Review other county and municipal EMS models.
C. Develop recommendations to ensure sustainable and effective EMS operations over the next decade.
D. Establish an action plan for the implementation of these recommendations

Adopted by the Chippewa County Board per Resolution 39-25

DRAFT - July 22, 2026

FINAL REPORT
TO THE CHIPPEWA COUNTY AD HOC EMS STUDY COMMITTEE

Comprehensive Operational Analysis, Policy Context, Framework Evaluation, and Strategic System Recommendations for Emergency Medical Services (EMS) in Chippewa County

Prepared by:
Community Development Educator
University of Wisconsin-Madison
Division of Extension

June 29, 2026

SECTION I: EXECUTIVE SUMMARY

Chippewa County's Emergency Medical Services (EMS) are at a breaking point. The system we built decades ago can no longer handle today's reality: an aging population, a severe shortage of emergency workers, and widespread burnout.

This report is the result of a thorough, data-driven study by the Ad Hoc EMS Committee. By analyzing map data from thousands of 911 calls in 2024 and 2025, auditing local ambulance rosters, and meeting directly with frontline crews, the committee has identified deep cracks in our county's safety net.

Key Findings: A System on Life Support

- **The Eastern Crisis:** The eastern third of our county is in danger. In this region, local ambulance services simply do not have the manpower to guarantee a crew will answer the call 24/7/365.
- **Extreme Burnout:** In some areas, the system is being held together by a thread. We found cases where just three volunteers are covering 87% of all on-call hours. This is completely unsustainable.
- **The Domino Effect:** When a local crew can't respond, an ambulance from a neighboring district has to cover for them. This "mutual aid" is supposed to be for rare emergencies, but it has become a daily band-aid. It strips fully-staffed districts of their own protection, leaving their residents vulnerable.
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The Recommendation: Protect Our Residents

Ambulance service is not a luxury—it is an essential part of public safety, just like the Sheriff's Department. Local towns and villages can no longer fix this on their own. We need county-level action.

The committee strongly recommends using county tax levy funds to immediately hire a County EMS Coordinator.

This professional will act as a lifeline for our local departments by focusing on:

- Immediate Relief: Assisting local chiefs with scheduling, cross-training, and workforce mental health to stop the bleeding.
- Long-Term Security: Leading the multi-year effort to transition Chippewa County away from a broken, piecemeal system and toward a unified, sustainable emergency response network.

Our residents expect that when they dial 911, an ambulance will show up. To guarantee that promise, the County Board must act now.

SECTION II: HISTORICAL BACKGROUND AND GROUNDWORK

1. The Macro-Evolution: From "EMS 1.0" to Systemic Crisis

To understand the current emergency medical infrastructure of Chippewa County, it is necessary to examine the historical baseline from which American rural EMS developed. Modern emergency medical response grew out of a fundamentally reactive, civic-volunteer mindset commonly referred to as "EMS 1.0." Before the late 1960s and early 1970s, localized medical transport was frequently an offshoot of regional funeral homes, utilizing hearses as the only available vehicles capable of transporting supine patients.

Following federal directives and the maturation of formal training curriculum standards, community-led, all-volunteer squads emerged across Wisconsin. These organizations relied on a social compact: community members, local farmers, business owners, and tradespeople volunteered their personal time to be on call, stepping away from their primary jobs or families at the sound of a civic siren or pager to staff the community ambulance.

For several decades, this "EMS 1.0" model functioned as an incredibly cost-effective and socially cohesive system. However, the foundational socioeconomic variables that supported it have fundamentally disintegrated:

- **The Training Burden**: Initial certification for basic Emergency Medical Technicians (EMTs) has risen dramatically in complexity and hour requirements, requiring hundreds of hours of advanced clinical instruction, continuing education units (CEUs), and rigid computer-based testing. This presents a high barrier to entry for the casual civic volunteer.
- **Economic Shifting and Commuting:** Rural economies have shifted; a substantial segment of the rural workforce no longer works within the immediate municipal boundaries where they reside. Commuting to urban centers prevents volunteers from being physically available for daytime emergency calls in their home districts.
- **Societal Changes:** Modern families balance multiple career and extracurricular commitments, reducing the pool of individuals willing to sacrifice night and weekend hours for minimal or non-existent stipends.

Consequently, the "all-volunteer" model has run its course. Systems nation-wide have shifted into a protracted crisis of reliability, transforming volunteerism from a sustainable civic asset into an unstable structural risk.

2. Local Synthesis: The Mobilization of Chippewa County

The local trajectory mirrors these national and state-level fractures, but accelerated sharply due to acute regional healthcare crises. In early 2024, the Hospital Sisters Health System (HSHS) announced the sudden closure of HSHS Sacred Heart Hospital in Eau Claire and HSHS St. Joseph's Hospital in Chippewa Falls, alongside several highly utilized Prevea Health clinical facilities. The sudden removal of these critical regional healthcare anchors caused immediate, profound downstream effects on local EMS operations. Transport distances increased as ambulances were forced to bypass local emergency rooms to transport patients to remaining regional centers. This severely lengthened "turnaround times" and kept precious rigs out of service for hours at a time, straining the financial resources of agencies and negatively impacting an already fragile system.

SECTION II: HISTORICAL BACKGROUND (CONTINUED)

Recognizing the accelerating unsustainability of the local framework, the **Chippewa County EMS Association**—a body representing the collaborative leadership of local transporting and non-transporting rescue entities—sounded an institutional alarm. The Association approached the Chippewa County Administrator to explicitly signal that the current system was on the verge of operational failure.

In response to these concerns, the County Board authorized the creation of the Ad Hoc Emergency Medical Services Study Committee. To ensure that solutions were not dictated in a top-down manner, a deliberate engagement strategy was constructed. The local University of Wisconsin-Madison Division of Extension Community Development Educator was embedded as a primary neutral facilitator and structural designer. The Extension Educator worked to build a collaborative process that bridged county administration with frontline stakeholders. This process brought together the localized, practical expertise of frontline EMTs, paramedics, and first responders, the administrative oversight of municipal town boards, and the policy-level focus of county government officials. This set the stage for an objective, data-driven, and participatory evaluation of the entire system.

Governance and Authority Structure

The Chippewa County Board of Supervisors created the EMS Ad-Hoc Study Committee (the committee). The committee is a temporary, specialized body established to investigate, analyze, and provide strategic recommendations regarding the county's emergency medical services. The county charged the committee to be a facilitating body, bringing relevant stakeholders together to discuss the opportunities and challenges regarding EMS within the county.

The committee's authority and reporting path flow as follows:

- Chippewa County Board of Supervisors (Ultimate Authority): Holds final legislative and financial authority over any proposed changes, budgetary allocations, or strategic overhauls regarding county-wide EMS operations.
- Executive Committee (Oversight & Liaison): Serves as the direct governing body overseeing the Ad Hoc Committee. To ensure proper administrative vetting, the Ad Hoc Committee must present its findings and recommendations to the Executive Committee approximately two weeks prior to any full County Board action.
- EMS Ad Hoc Committee (Working Body): The 13-member appointed body tasked with gathering data, collaborating with local stakeholders, and drafting the final strategic recommendations due by August 11th.

Committee Composition

To ensure a balanced, equitable, and comprehensive approach to county-wide EMS planning, the Ad Hoc Committee comprises 13 appointed members. The composition intentionally balances county governance, specific municipal interests, rural town representations, and frontline EMS professionals.

The 13 seats are distributed across the following stakeholder groups:

- County Governance (2 Seats)
  - County Supervisors (2): Provide direct alignment with county-wide legislative priorities, fiscal policy, and board expectations.
- Municipal Representation (6 Seats)
  - Local Municipalities (6): Dedicated seats representing a diverse mix of cities, villages, and established fire/EMS districts within the county. This includes representation from:
- Towns Association (2): Ensures that the unique geographic, financial, and logistical needs of the county's rural townships are strongly voiced and protected.
- Frontline EMS & Provider Representation (3 Seats)
  - EMS Agency Representatives (2): Comprising one (1) Rural Representative and one (1) Urban Representative to address the distinct operational challenges faced by different service areas.
  - EMS Association Chair (1): Serves as the vital structural bridge between the Ad Hoc Committee and the broader Chippewa County EMS Association. This seat ensures that provider-level survey data, SOAR analyses, and field-level feedback directly inform the committee's final recommendations.

The Work & Collaboration (Timeline)

The relationship between the Ad Hoc Committee and the Chippewa County EMS Association is all about data gathering and a major mid-point collaboration.

Here is how the workflow unfolded chronologically leading up to the final deadline:

Phase 1: Groundwork & Data Gathering (Early 2026)

- January 2026: The EMS Association conducts a SOAR Analysis (Strengths, Opportunities, Aspirations, Results) with providers to figure out the current landscape.
- March 2026: The EMS Association gathers feedback on a proposed survey tool.
- April 2026: Two separate surveys are administered—one to all individual EMS providers and one to each EMS Director/Agency.

Phase 2: The Collaboration Touchpoints

While the Ad Hoc Committee was holding regular monthly meetings (Jan, March, April, May), two massive touchpoints bridged the Committee and the Association together:

- The EMS Association Chair: Sits permanently on the Ad Hoc Committee as one of the 13 members.
- The June 4th Combined Meeting: This was the peak collaborative event. Agency Directors and two representatives from each each agency were invited to sit down with the Ad Hoc Committee to review all the survey data collected in April and map out initial strategies/recommendations.

Phase 3: The Finish Line

- Late June / July: The Ad Hoc Committee refines the data from that June 4th meeting (holding another follow-up meeting on June 25th).
- Late July: The final report is presented to the Ad Hoc Study Committee to review in advance of early August meeting
- August 11th: The anticipated deadline to hand over the final recommendations to the County Board with findings to be shared with County Executive Committee in September.

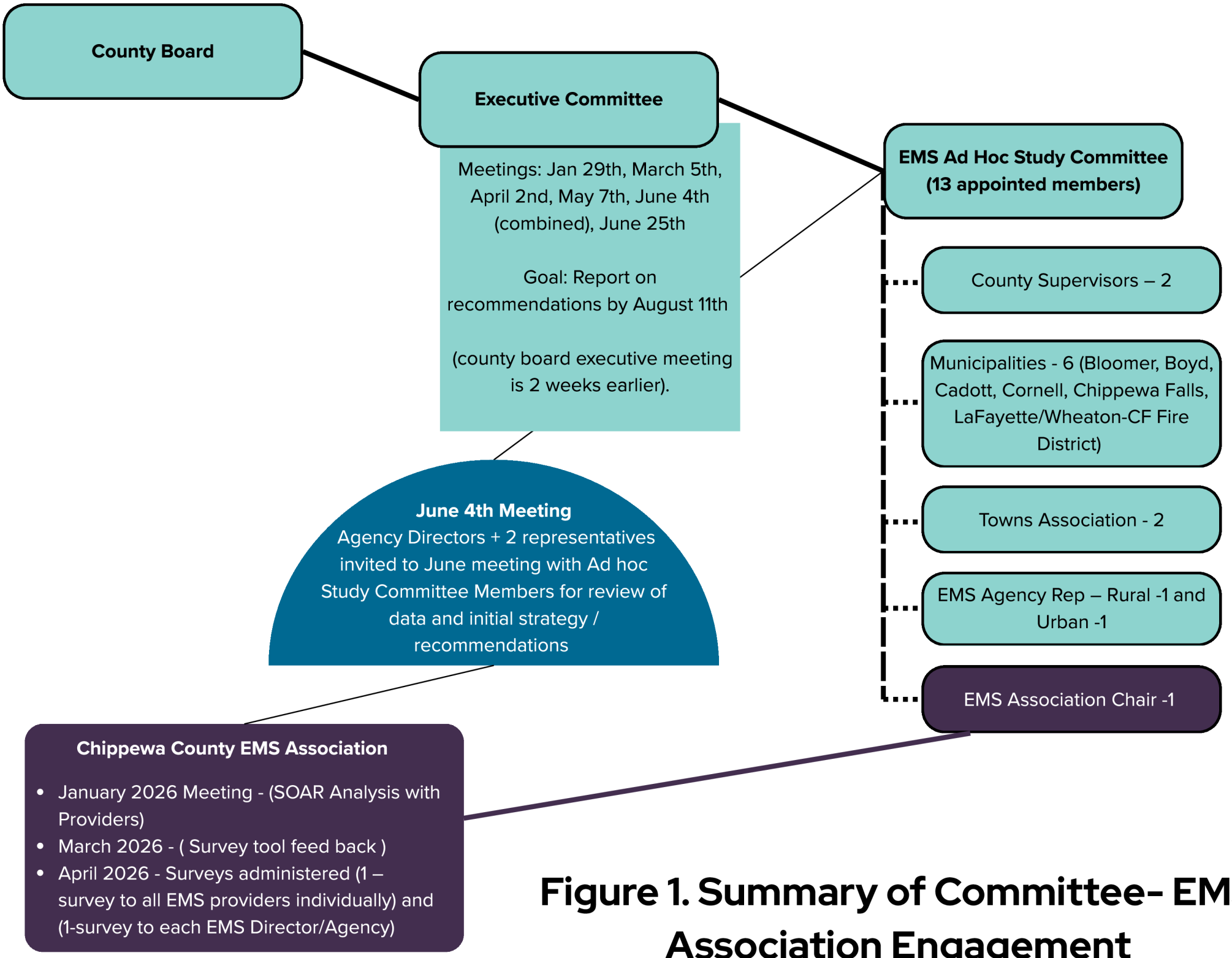


Figure 1. Summary of Committee- EMS Association Engagement

SECTION IV: THE LEGISLATIVE AND POLICY CONTEXT

Any structural or financial recommendation made by this committee must be firmly grounded within the statutory guardrails established by the State of Wisconsin. The policy landscape governing EMS is highly distinct from other public safety pillars like law enforcement or fire protection. It features explicit municipal obligations, operational mandates, and highly specific tax levy exceptions.

1. Statutory Municipal Obligations & Availability Mandates
Under the Wisconsin State Statutes, the legal mandate to provide emergency medical and ambulance transport services rests firmly at the municipal level, rather than with county government:

- **Towns: Wis. Stat. § 60.56**5 dictates that a town board shall contract for, operate, or maintain ambulance services for the township unless such services are explicitly provided by another public or private entity.
- **Cities and Villages: Wis. Stat. § 61.64** and parallel chapters state that villages and common councils may purchase, equip, operate, and maintain ambulances or contract for such coverage.

Crucially, the operational mandate tied to these statutory obligations is uncompromising. Any licensed EMS agency designated as a primary transporting provider is legally guaranteeing to the state and its constituents that they will maintain operational availability 24 hours a day, 7 days a week, 365 days a year (Wisconsin Administrative Code DHS 110.34(5)).

> "Assure response to 9-1-1 emergency response requests **24 hours-a-day, 7 days-a-week**, in its primary service area unless it is not licensed to do so.
> *Wisconsin Administrative Code DHS 110.34(5).*

The only mechanism to deviate from this absolute baseline is if an agency formally petitions and receives an explicit waiver from the Wisconsin Department of Health Services (DHS) to operate at a less frequent, restricted rate. To secure such an exemption, the requesting agency must present formal, binding structural agreements with neighboring agencies that explicitly agree to cover the unstaffed hours. These formalized coverage agreements must be entirely distinct from standard, back-up mutual aid protocols. Notably, Emergency Medical Responder (EMR) services are exempt from these requirements; while their hands-on care is valuable, they are not statutorily required. An ambulance is legally mandated to exist and respond, whereas an EMR group is not a statutorily required system.

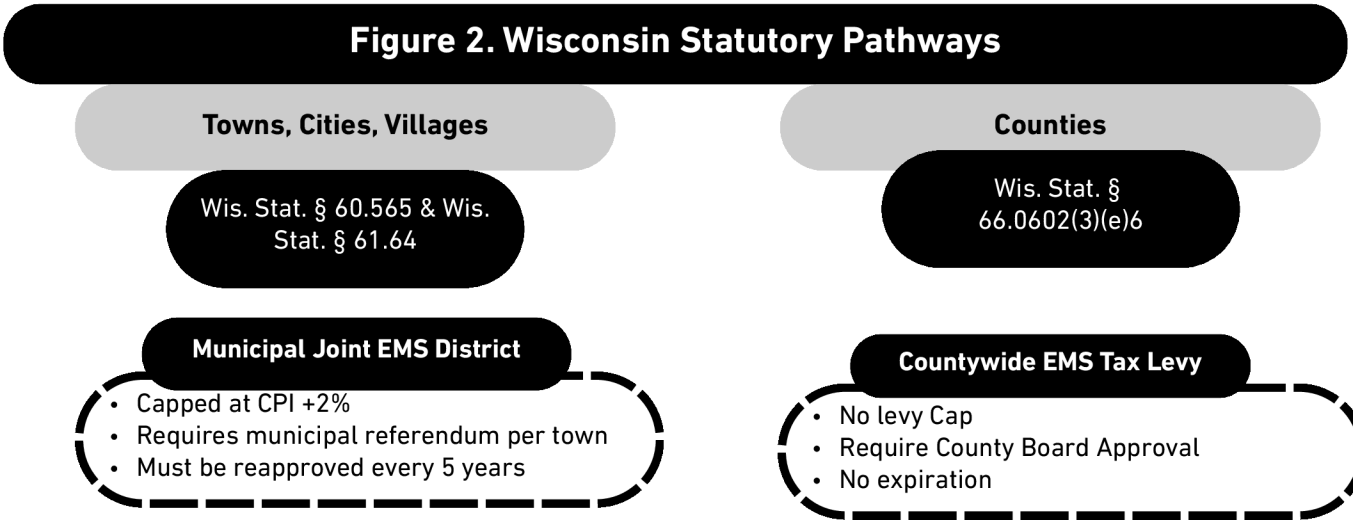
> Emergency medical responder services are exempt from this requirement [24/7 coverage] but should assure every effort is made to respond to 9-1-1 requests."
> Wisconsin Administrative Code DHS 110.34(5).

2. Tax Levy Limits and Financial Exceptions

Wisconsin strictly limits the amount of property tax revenue that political subdivisions can levy from year to year. However, the legislature has recognized the severe structural headwinds facing emergency medical infrastructure and has provided two distinct statutory exceptions to bypass these levy limits:

- **The County-Level Pathway (Wis. Stat. § 66.0602(3)(e)6):** This statutory provision creates an explicit exception to a county's structural levy limit for the exact amount that a county board levies in a given fiscal year to fund a countywide emergency medical system (though it does not require the county to own and operate EMS services). This mechanism is highly efficient. It requires only a majority vote of the established County Board of Supervisors to enact, providing a stable, unified, and countywide funding source to strengthen the regional emergency safety net without impacting existing municipal caps.
- **The Municipal Joint District Pathway (2025 Wisconsin Act 212 / Wis. Stat. § 66.0602(3)(o)):** Enacted by the most recent state legislature, Act 212 allows local municipalities (towns, villages, and cities) to exceed their local levy limits to fund the eligible costs of a "qualified joint EMS district" or joint fire department. However, this municipal pathway is constrained by strict statutory limitations:
  - **Financial Cap:** The levy increase is strictly capped at the rate of the Consumer Price Index (CPI) plus two percent for the relevant fiscal year.
  - **Referendum Mandate:** The exception cannot be enacted by a simple board vote; it requires formal approval via a public referendum across every participating municipality within the district's territory.
  - **Sunset Provision:** The referendum approval is not permanent; it features a strict sunset clause requiring public re-voting and re-approval every five years.

This policy context shows that while municipal districts are an option, they carry a high administrative burden, structural caps, and long-term instability due to recurring referendums. Conversely, the countywide EMS levy offers a clear, flexible, and sustainable mechanism to build long-term operational resilience.



SECTION VI: METHODOLOGY AND DATA COLLECTION PROCESS

To build a defensible foundation for its eventual recommendations, the Ad Hoc Committee rejected anecdotal claims and executed a rigorous, multi-tiered data gathering and analytical framework.

Table 1: Committee Data Methodology	
Primary and Secondary Literature	Office of Rural Health, Policy Forum, La Follette Capstone, Previous Chippewa County Reports
GIS Call Analysis	Geocoding and mapping of 2024 and 2025 calls to trace call response locations
Roster and Hours Audit	Cross-Matching logbooks to check actual vs. "ghost" staffing lists
Qualitative Engagement	Surveying frontline crew, SOAR strategic alginment sessions, joint meeting with EMS Association, panel presentation from other Wisconsin Counties

1. Review of Primary and Secondary Literature and Existing Research

The committee began its research by conducting a deep-dive review of extensive state-level and regional macroeconomic assessments. This baseline analysis included:

- **The Wisconsin Office of Rural Health (ORH) Reports:** Reviewing the landmark Reliability of Wisconsin's 911 Ambulance Response studies, which detailed the statewide decline in rural staffing capacity.
- **Wisconsin Policy Forum Analyses:** Reviewing structural studies outlining the mounting operational deficits within municipal fire and EMS divisions across the state.
- **UW-Madison La Follette School of Public Affairs Capstone Project:** Evaluating advanced academic modeling and structural strategies aimed at stabilizing rural EMS delivery through collaborative, regional models.
- **Historical Baseline Review:** Analyzing the preliminary data collected internally during the fall of 2024, which provided the first clear warnings of local system fragility.

2. Comprehensive GIS Geographic-Call Mapping (2024–2025)

To move from abstract state trends to local realities, the committee instructed county administrative and dispatch staff to conduct an Geographic Information Systems (GIS) spatial analysis. This project mapped all emergency EMS dispatches activated across Chippewa County throughout the calendar years 2024 and 2025.

The analytical parameters mandated:

- The precise geocoding of every emergency call location.
- Tracking and documenting the exact responding agency for every incident.
- Overlaying response onto established municipal boundary maps.
- Evaluating the frequency and spatial layout of cross-district dispatches (instances where an agency was forced to respond to an emergency completely outside its designated home zone).
- Identifying regional "hot zones" or clusters experiencing prolonged response times or high densities of dropped calls.

3. Detailed Roster and Availability Audits
Simultaneously, the committee executed an internal operational audit of individual agency data. This required collecting and cross-matching anonymized personnel rosters against the actual, verified on-call hours logged by individual emergency responders.

This process was designed to separate “paper rosters” (the total number of licensed individuals technically listed on an agency’s roster) from “operational rosters” (the individuals actually covering hours on the active weekly schedule).

4. Primary Stakeholder Surveys
To evaluate the human element driving these systems, two distinct survey instruments were deployed in the spring of 2026:

- **Frontline Provider Survey:** Target-sampling EMTs (Emergency Medical Technicians), Advanced EMTs, Paramedics, and Emergency Medical Responders (EMRs). This survey evaluated personal well-being metrics, systemic burnout levels, baseline motivations for entering and remaining in the field, identified local operational assets, and perceived structural vulnerabilities.
- **Agency Director Survey:** Querying regional service chiefs and directors regarding scheduling software access, budget constraints, capital replacement schedules, and localized operational challenges.

5. Participatory Stakeholder Workshops
The quantitative data was balanced by qualitative stakeholder workshops designed to foster transparent communication:

- **January 2026 SOAR Analysis:** Facilitated by Committee Chair and County Board Supervisor Pam Guthman, alongside the local Division of Extension Educator, Department of Emergency Management, and the Department of Public Health. Representatives from throughout the Chippewa County EMS Association mapped the system’s Strengths, Opportunities, Aspirations, and Results.
- **June 2026 Joint Ad Hoc Summit:** A collaborative, facilitated workshop that brought together the members of the Ad Hoc Study Committee, municipal leaders, and a wide array of frontline providers and agency chiefs to review data, resolve long-standing debates, and establish shared operational priorities.

6. Learning from Other Counties
The committee held a virtual panel with representatives from Bayfield, Lafayette, and Portage Counties to understand how and why their counties involved themselves in EMS. Panelists shared advice and recommendations on how Chippewa County might proceed moving forward.

SECTION VII: CORE FINDINGS AND CURRENT SYSTEM DIAGNOSIS

The integration of these diverse data streams produced a clear, stark diagnosis of the county's current emergency medical infrastructure. The data shows that the county is operating a fractured system that survives only on the extreme, unsustainable efforts of a very small number of people.

1. Annual Coverage vs. Operational Minimums

To guarantee a reliable 24/7/365 ambulance response with a minimum two-person crew, an individual agency must log a baseline minimum of 17,520 on-call hours annually (8,760 hours/year × 2 crew positions). The comprehensive 2025 cross-sectional operational audit exposed a profound geographic divide in meeting this safety minimum:

Table 2. Agency Coverage Results

Agency	Municipalities Covered	Total 2025 Verified Hours	% of 24/7 Mandate	Systemic Status
Bloomer Ambulance	Towns: Sampson, Auburn, Bloomer, Cooks Valley, Woodmohr; Cities of Bloomer, Village of New Auburn; Parts of Tilden, Eagle Point, Cleveland	22,344.0	128.0%	Exceeded Minimum (Stable)
Boyd-Edson-Delmar (Boyd)	Towns of Delmar, Edson, Village of Boyd, City of Stanley; Part of Colburn	17,859.0	101.9%	Met Minimum (Fragile Balance)
Cornell Area Rescue Squad	City of Cornell, Towns of Estella, Lake Holcombe, Birch Creek; Parts of Arthur, Cleveland, Colburn, Eagle Point, and Ruby	15,565.0	88.8%	-1,955 Hour Coverage Deficit
Cadott Community Ambulance	Towns of Goetz & Sigel, Village of Cadott; Part of Arthur	12,238.0	69.9%	-5,282 Hour Coverage Deficit

The data proves that while Bloomer is structurally sound for a first-due Ambulance and Boyd mathematically maintains a narrow baseline, Cadott faces a severe 30.1% coverage gap, and Cornell experiences an 11.2% operational deficit. For substantial portions of the year, these eastern districts do not have an active, staffed crew available to respond to emergencies in their home territories.

2. Extreme Labor Concentration and "Heavy Hitter" Reliance

A deeper analysis of active schedules shows that even agencies that mathematically meet or approach their annual hour requirements are standing on the brink of structural failure. Roster numbers are highly misleading, as a very small group of individual responders shoulders almost the entire operational burden:

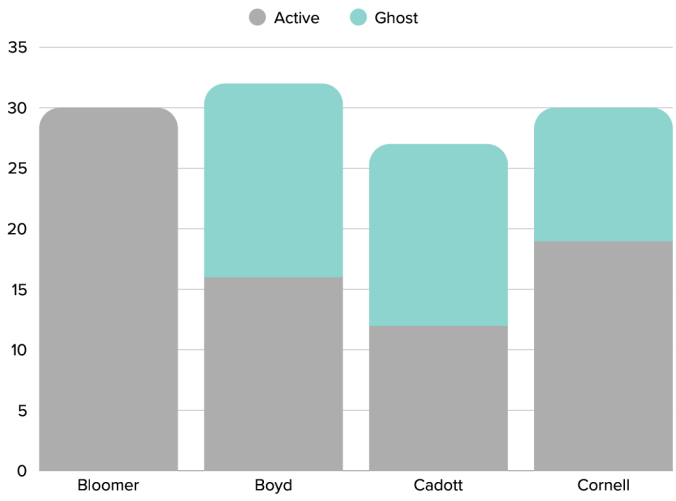
- **Boyd-Edson-Delmar:** Just **3 individuals** provide 83.7% of the agency's total hours.
  - Responder #16 alone logged 7,974.75 hours—nearly 45% of the agency's entire hours.
- **Cadott Community Ambulance:** The top 5 individuals provide 85.2% of the agency's coverage (10,424.5 of 12,238).
- **Cornell Area Rescue Squad:** The top 7 individuals provide 81.3% of total hours (12,654 of 15,565). Responder 1 provided 18% of all hours in 2025. Responders 7, 8, and 18 provide 20% of hours yet are only seasonal crew members

3. The "Ghost Roster" Phenomenon

The audit exposed that large roster numbers frequently mask acute operational fragility. A substantial portion of the personnel listed on paper are entirely inactive or minimally active, a dynamic defined as the "Ghost Roster". The chart below indicates the number of individuals on the agencies roster in 2025 who went who were schedule for at least one hour in 2025 compared to those who were on-call for zero hours (our ghosts).

- **Cadott Community Ambulance:** Features a 55.6% Ghost Roster, with 15 out of 27 listed members logging exactly 0 on-call hours.
- **Boyd-Edson-Delmar:** Features a 50.0% Ghost Roster, with 16 out of 32 listed members logging 0 on-call hours.
- **Cornell Area Rescue S**quad: Features a 36.7% Ghost Roster, with 11 out of 30 listed members logging 0 on-call hours.
- **Bloomer Ambulance**: By contrast, Bloomer exhibits a 0% Ghost Roster (0 out of 30 members logged 0 hours), heavily driven by their implementation of a flat-rate on-call pay model that effectively incentivizes active scheduling.

Figure 3 Active vs Ghost Roster



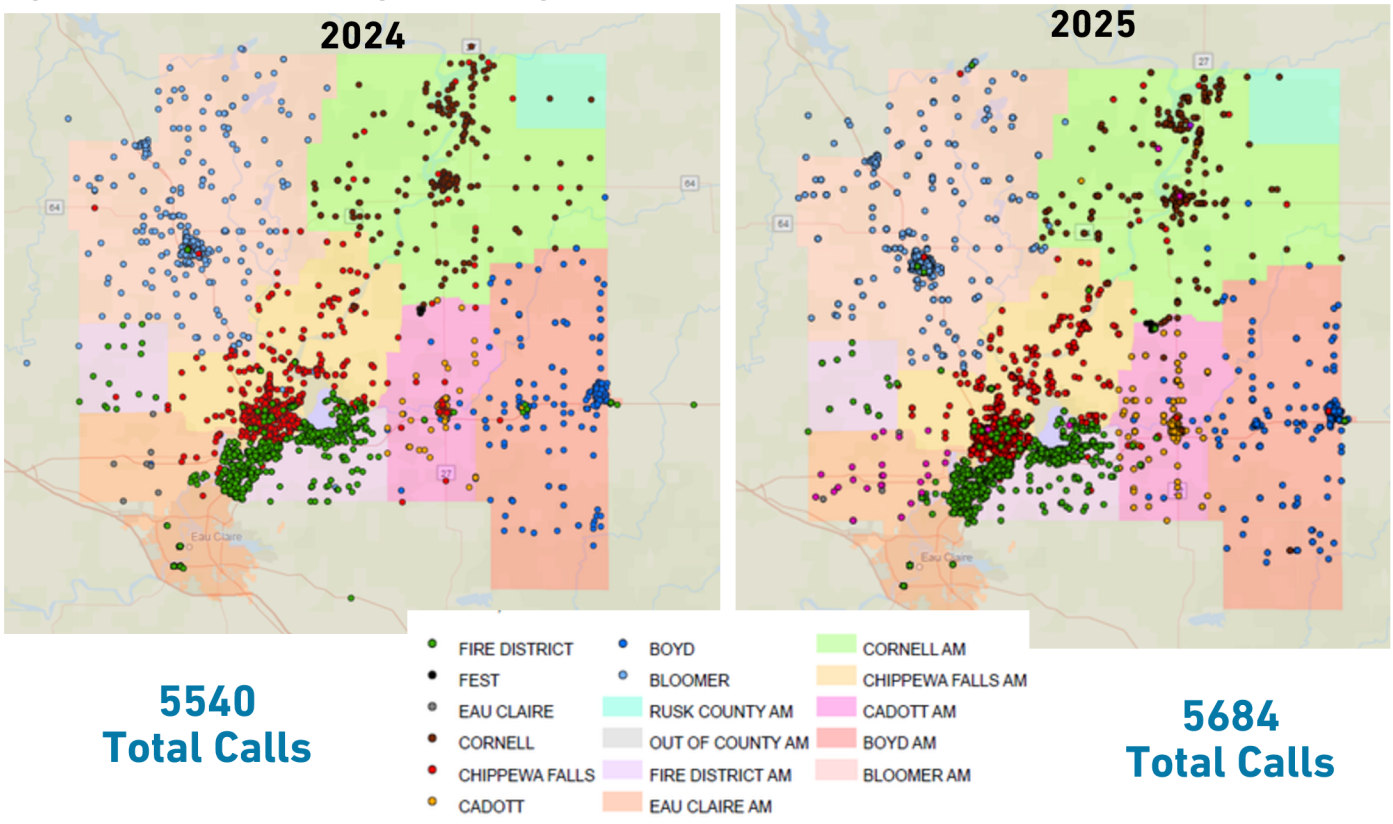
Crucially, the data reveals a high reliance on "pager-only" response from inactive on-call members. In Cadott, the 15 individuals who logged 0 scheduled on-call hours still responded from home to handle 259 emergency incidents. In Boyd, 10 of the zero-hour responders collectively answered 55 calls, and in Cornell, only three responders operated this way.

While this un-scheduled response shows incredible personal dedication, it creates a severe operational risk. It means the community's emergency safety net is completely dependent on un-scheduled individuals happening to be in town, near the station, and available when a call goes out. This completely fails the statutory requirement to guarantee a 24/7/365 structured response.

4. The Cascade Effect and the Distortion of "Mutual Aid"

When an eastern agency cannot staff a rig for a dispatched call due to these deep scheduling gaps, it triggers a severe "cascade effect" across the county's geography:

Figure 4: Maps Representing Calls By Agency in Districts



The GIS mapping from 2024 and 2025 shows that fully-staffed core agencies are consistently drawn out of their primary districts to cover recurring gaps in unstaffed zones. Consequently, this creates secondary coverage gaps within the core zones. If a simultaneous emergency occurs within the core district, dispatch is forced to call in ambulances from entirely separate, neighboring counties to cross borders into Chippewa County.

Defenders of the status quo often label this dynamic as standard "mutual aid." However, the committee's findings firmly reject this characterization. True mutual aid is built on strict reciprocity—a mutual agreement where Agency A covers Agency B during a rare, overwhelming emergency, and Agency B returns the favor under similar circumstances.

What is occurring in Chippewa County is a structural subsidization. One set of taxpayers and staffed agencies is continuously absorbing the daily operational deficits of communities that fail to provide adequate personnel for their own first-due responses. A lack of regular schedule staffing is an ongoing operational failure, not an unpredictable emergency.

5. The Distortion of "Mutual Aid"

When a localized, municipal EMS service suffers a systemic staffing deficit, the operational impact is rarely contained within that single municipality's borders. Instead, it triggers an ongoing "cascade effect" that degrades response times, introduces profound geographic risks, and strains the resources of neighboring communities across Chippewa County.

The Outbound Strain: Who is Absorbing the Burden?

The first half of this phenomenon is documented below, showing the total volume of emergency calls answered by primary agencies completely outside of their home response zones (in yellow). As the data illustrates, agencies with structurally secure or hybridized staffing models are consistently drawn away from their primary jurisdictions. This is not a case of an occasional long-distance transport; it is a structural necessity driven by baseline coverage gaps elsewhere.

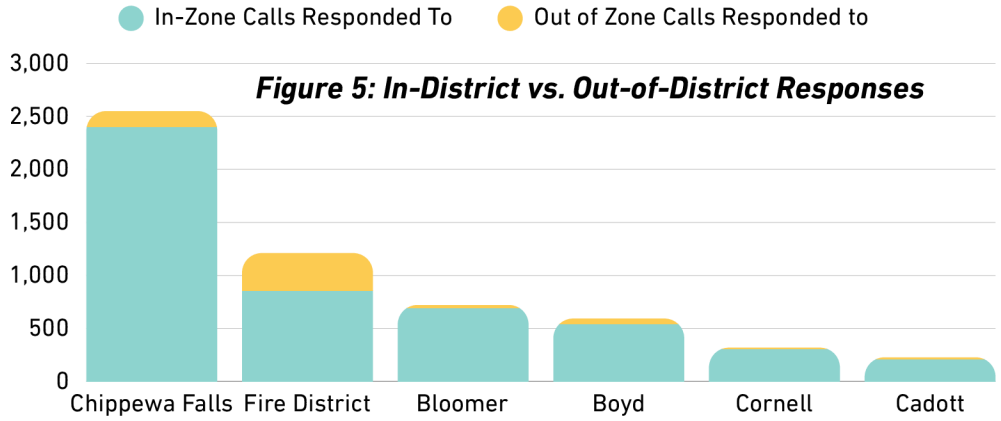


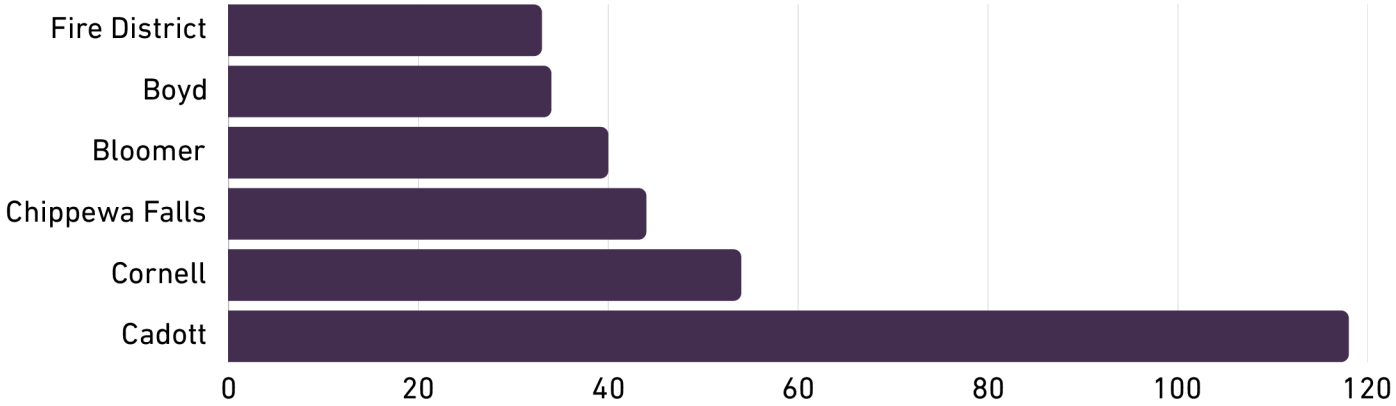
Figure 5: In-District vs. Out-of-District Responses

When a well-staffed agency routinely leaves its district to cover a neighboring vacancy, it creates an immediate, temporary coverage vacuum in its own backyard. If a high-acuity emergency occurs within the core zone while that rig is away, dispatch is forced to call an even more distant unit—or a crew from an entirely different county—to cross borders and fill the secondary gap.

The Inbound Subsidization: Who is Relying on "Backfill"?

The second half of the equation maps exactly where these outside resources are being deployed to plug operational holes. Figure 6 represents the zones where agencies delivered “mutual aid.”

Figure 6: Outside Agency Arrivals by Service Zone



This visualization pinpoints the key sites of the crisis, concentrated heavily across the county's eastern and northeastern corridors. Because these areas experience prolonged scheduling gaps where no "first-due" crew can be fielded, they require continuous, structural stabilization from external units just to maintain basic 911 coverage. For example, Cadott (which had a -5,282 Hour Coverage Deficit) did 0 mutual aid calls in 2025 (see Figure 6). However, inside their response district, outside agencies completed 118 calls (see Figure 7).

Redefining the Illusion of "Mutual Aid"

Defenders of the uncoordinated status quo frequently categorize these cross-district movements as standard, healthy "mutual aid." However, the committee's findings firmly reject this label.

- **True Mutual Aid** is built on strict reciprocity. It is a mutual agreement where Agency A occasionally covers Agency B during a rare, overwhelming emergency (such as a multi-vehicle mass casualty incident), and Agency B reliably returns the favor under similar circumstances.
- **Structural Subsidization** occurs when one group of municipal taxpayers funds a staffed, reliable service, only to have that service continuously absorbed by a neighboring district that fails to provide or fund its own adequate personnel.

A routine, predictable scheduling vacancy is an operational failure, not an unpredictable emergency. Using a neighboring town's ambulance as a default primary responder stretches our county's emergency safety net to a dangerous breaking point—leaving both districts vulnerable and accelerating the burnout of the remaining crews.

6. Frontline Provider Burnout and Moral Injury

The frontline survey findings paint a distressing picture of the psychological toll this structural subsidization exacts on personnel. The data reveals critical rates of chronic burnout, exhaustion, and structural isolation among both frontline staff and agency chiefs. In Table 3, respondents indicate both guilt for not having sufficient staff. While explicit agreement regarding hypervigilance and sleep disruption sat at 21%, nearly a third of respondents (31%) remained neutral. In total, over half of the surveyed workforce (52%) could not definitively state that they sleep well or feel at ease.

Crucially, responders highlight a sense of institutional guilt and moral injury. Because they know the system is fragile, individual EMTs and volunteers describe feeling trapped into working unsustainable, consecutive shifts. They know that if they log off the scheduling system to rest, their neighbors' emergency calls may go completely unanswered, or a neighboring crew will be forced to drive 20 miles across the county to handle the call. This environment creates a toxic cycle: structural staffing deficits drive extreme overwork, which accelerates acute burnout, ultimately driving the remaining "heavy hitters" out of the service entirely.

Table 3. Front Line Responses on Wellbeing

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Psychological Safety: I can approach a supervisor without fear to discuss concerns.	10.34%	5.17%	8.62%	37.93%	37.93%
Staffing Guilt: I feel personal guilt if we do not have sufficient staffing.	**3.45%**	**12.07%**	**18.97%**	**37.93%**	**27.59%**
Well-being: I often feel "on edge" or have difficulty sleeping.	**10.34%**	**36.21%**	**31.03%**	**13.79%**	**8.62%**
Clinical Confidence: I am confident in my skills when I respond to a call.	0.00%	1.72%	8.62%	51.72%	37.93%

SECTION VIII: RECOMMENDATIONS AND THE PROPOSED STABILIZATION PATHWAY

The Ad Hoc Study Committee has arrived at a firm consensus: **Chippewa County must make a strategic investment in its emergency medical services utilizing county-level tax levy mechanisms.** The current model of uncoordinated municipal isolation is clinically, operationally, and ethically unsustainable.

However, the committee also firmly establishes a secondary principle: It is not the role of this ad hoc body to unilaterally dictate, impose, or construct a rigid, top-down county-operated EMS model. EMS architecture is highly complex, and the underlying statutory authority remains distributed across local municipal lines.

Therefore, the committee recommends a phased stabilization pathway that uses county funds to strengthen the local system from within, rather than replacing it with an expensive, top-down bureaucracy.

1. Immediate Primary Recommendation: Funding the County EMS Coordinator

The centerpiece recommendation of this report is the immediate allocation of initial county tax levy funds—leveraging the clear exception provided under Wis. Stat. § 66.0602(3)(e)6—to establish and fund a County EMS Coordinator position. This position will be housed administratively within county staff and will serve as the central coordinating hub for regional stabilization. The recommendation is this position would report directly to the County Administrator with advisory guidance by an EMS Advisory Committee.

The Coordinator's immediate, short-term focus will be to relieve the operational pressures crushing frontline providers and agency chiefs:

- **Intergovernmental Trust-Building and System Collaboration:** Cultivating trusted, collaborative relationships across individual EMS agencies, municipal and town leadership, local higher education institutions, and county government.
- **Chief Leadership Development:** Creating structured, professional development and technical training pipelines for regional agency chiefs. This will provide them with modern tools to handle budgeting, human resources, state compliance, and operational management.
- **Administrative and Scheduling Optimization:** Deploying county-supported electronic scheduling platforms and administrative assistance to standardize and streamline schedule management. This will ease the reporting burdens that take local chiefs away from direct operational oversight.
- **Provider Well-Being and Mental Health Support:** Designing, funding, and deploying structured peer-support networks, professional psychological service pipelines, and workplace wellness initiatives to address the high rates of provider burnout and moral injury.

ROLES OF THE NEW COUNTY EMS COORDINATOR

Phase I: Immediate Stabilization

- System Collaboration: Building trusted relationships to facilitate improvements
- Chief Leadership Development: Providing technical & operational tools
- Administrative Support: Standardizing countywide scheduling systems
- Provider Well-being: Deploying formal mental health & wellness assets

Phase II: Strategic Structural Transformation

- Evaluate Levy Allocation Models (e.g., Bloomer/Colfax models)
- Negotiate Municipal Collaborations & Shared Districts
- Manage Long-Term Transition: Vol. Hybrid -> Professional -> Full-Time

2. Long-Term Mandate: Navigating the Structural Evolution

Beyond immediate operational stabilization, the County EMS Coordinator will be charged with a long-term strategic mandate. Because emergency medical services are highly complex and legally tied to municipal governments, navigating a permanent structural solution requires a dedicated professional. They must have the time and expertise to lead detailed multi-year negotiations across town, village, city, and county lines.

Moving forward, the Coordinator will evaluate the strategic use of county levy funds, analyzing which structural models best fit Chippewa County's distinct regions. This analysis will guide the system through three potential long-term structural options:

- **Option A: The Sustained Volunteer/Hybrid Model Optimization:** Evaluating whether county levy funds should be distributed directly to support and stabilize existing local agencies. This approach would help them transition toward highly effective, modernized paid-on-call or hybrid models—patterned after resilient local services like the Bloomer or Colfax ambulance structures.
- **Option B: Structural Regionalization and District Integration:** Leading the legal, financial, and physical negotiation required to merge the infrastructure of vulnerable municipal services into unified, multi-jurisdictional ambulance districts. This could include contracting and collaborating with existing professionally staffed agencies (e.g., Chippewa Fire or Chippewa Falls) along with consolidation of existing agencies.
- **Option C: Targeted Professionalization and Core Extension:** Evaluating whether the county should systematically shift toward a highly professionalized, full-time staffing matrix. This model could involve funding existing full-time professional agencies to absorb vulnerable physical plants and directly extend their full-time coverage into the county's eastern gaps.

SECTION IX: CONCLUSION

The data compiled by the Ad Hoc EMS Study Committee confirms that the traditional "EMS 1.0" volunteer model in Chippewa County can no longer protect public safety on its own. The eastern third of our county is facing a quiet, dangerous crisis—sustained only by a tiny group of exhausted responders and an unstable cross-district subsidization network that strains our entire system.

Fortunately, Wisconsin law provides a clear, sustainable way forward. By using a countywide EMS tax levy, the County Board can inject vital resources exactly where they are needed most without placing an undue burden on local municipal caps.

The establishment of a County EMS Coordinator represents a balanced, highly strategic first step. This approach avoids creating an immediate, rigid county bureaucracy, choosing instead to protect and strengthen our existing local services. It provides the dedicated leadership and coordination needed to heal our frontline workforce, support our local chiefs, and guide Chippewa County toward a unified, sustainable, and completely reliable emergency medical system.

Thank Yous

Committee Members:

- Pam Guthman, County Board Supervisor, Chair
- Peter Gehring, County Board Supervisor, Vice-Chair
- Sandi Frion, Bloomer City Administrator
- Dale Isaacs, Boyd Village Board
- Eric Weiland, Cadott Village Board
- Deb Semanko, Cornell City Council
- Dan Dixon, Chippewa Falls City Council
- Dave Staber, Town of Lafayette Chair
- Corey LaNou, Town of Arthur Chairman
- Pauline Spiegel, Town of Eagle Point Supervisor
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APPENDIX: PROPOSED OPERATIONAL TIMELINE FOR THE EMS COORDINATOR

Quarter 1: Foundation and Relationship Mapping (Listening & Validation)

- **Conduct a "Trust-Building Tour":** Host individual listening sessions with the boards and staff of the primary agencies
- **Establish Higher Education Alliances**: Initiate meetings with institutions like CVTC and local school districts to outline the "Tuition-for-Service Pipeline" and high school EMT training models.
- **Vet Leadership Content Experts: I**nstead of delivering content directly, the Coordinator will identify external specialists to develop the programs to address identified management concerns.

Quarter 2: Collaborative Piloting and Soft Interventions (Early Wins)

- **The Consensus Summit & Contract Blueprint:** Convene all municipal and agency leaders to vet distinct policy pathways for the county levy and reach a formal agreement on the specific model to move forward.
- **Execute a Fiscal Impact Study:** Work with County Finance to model the countywide EMS levy exception (Wis. Stat. § 66.0602(3)(e)6), comparing the cost of investment vs. the liability of system collapse.
- **Launch the "Neighbor Burden" Education Campaign:** Begin a communication plan to inform the public and elected officials about the cascading calls to normalize future levy discussions.
- **Town Board Education:** Launch a brief “Roadshow” to educate individual town boards and county committees on the challenges of EMS and the potential models to strengthen the system.

Quarter 3: Model Refinement and Fiscal Stress Testing (Designing the Levy)

- **Formal Advocacy & Budget Integration:** Present the selected consensus model directly to County Committees and Town Boards to secure necessary local resolutions and ensure the intervention is built into the upcoming municipal and county budgets
- **Pilot a County-Wide Joint Training:** Organize a low-stakes clinical training session to build professional camaraderie and test the feasibility of Unified Medical Protocols.
- **Implement Responder Wellness Pilots:** Introduce a "Peer Support" or "Personal Leadership Check-in" framework EMS burnout, fatigue, and likely PTSD.

Quarter 4: Consensus Building and Implementation Roadmap

- **Secure Final Policy Pathways**: Present the choice between a County EMS Levy or Act 212 EMS Districts to the Board, supported by the year-long record of committee consensus.
- **Formal Resolutions & Implementation Training:** Secure final local resolutions from Town Boards to authorize the new Reliability Contracts, while simultaneously launching pilot modules for responder wellness and leadership development to stabilize the existing "Heavy Hitters"