Response to Initial Data Request (IDR)

I. DESCRIPTION OF PRE-HOSPITAL MEDICAL TRANSPORTATION SYSTEM

A. SERVICE AREA DESCRIPTION

1. How many square miles is the primary service area?
   Anderson County is 345 square miles.
   Per Wikipedia: "According to the U.S. Census Bureau, the county has a total area of 345 square miles (890 km²), of which 337 square miles (870 km²) is land and 7.6 square miles (20 km²) (2.2%) is water."

2. What is the population of the primary service area?
   Anderson County has a population of 75,936 according to the latest census data

Geography	April 1, 2010 Census	Population Estimate (as of July 1) Estimates Base	2010	2011	2012	2013	2014	2015	2016
Anderson County, Tennessee	75,129	75,094	75,126	75,179	75,326	75,420	75,347	75,698	75,936

3. Describe the make-up of your service area (e.g. rural, suburban, metropolitan, urban, or a combination).
   Anderson County has a make up of urban and rural. According to CMS though we are all urban.
   RW: Approximately 60% (45,000) in 5 municipalities ranging in size from 1,500 to 29,000. Clinton and Oak Ridge have the largest municipal populations at 9,800 and 29,000, respectively.

4. Attach a highway map of the area that clearly shows the base of operations, ambulance posts, and ambulance districts (if utilized), hospitals, primary nursing homes or other clients and the boundaries of the primary service area.
   Attachment I.A.4 is a map I made from google earth, I added in spots for our stations, our local hospital plus neighboring county hospitals, as well as nursing homes in our county. I made a generic border for the area of Roane County that we are contracted to provide services to.

5. Please describe any significant changes to the local economy over the past three years, including employers, contractors, layoffs, etc.
   Nothing of note as "significant"

B. GOVERNMENTAL RELATIONS

1. Provide a copy or references to any local ordinances and regulations governing or licensing ambulance services.
   Attached: County Resolution

2. Provide a copy of or references to the state legislation, rules, and regulations governing ambulance services.
   Attached: State EMS Rules and T.C.A.

3. Describe the service's relationships with local governments.
   Anderson County EMS provides EMS service to all of Anderson County, to include all municipalities within Anderson County. Anderson County EMS has a first responder agreement with all municipal fire departments and volunteer departments.

4. Describe the process by which the rates or increases are approved.
   When changes are being asked for by EMS, EMS presents those proposed rates to the County Operations Committee. Rates are discussed and voted on at this committee, then passed on to full County Commission for vote of approval.

C. ACCREDITATION

If accredited by the Commission on Accreditation of Ambulance Services (CAAS) or other accrediting body, please include;

1. Program Application or Program Information Form (PIF).
   N/A

2. All correspondence from the accrediting body.
   N/A

II. OPERATIONS

A. ACTIVITY LEVEL

1. How does your service primarily classify ambulance assignments? (e.g. emergency, and non-emergency, ALS and BLS, etc.) In what configuration do you staff each? (e.g. EMT/EMT, EMT/EMT-P)
   We switched to an all ALS service a few years ago. Due to staffing issues we have one ambulance that is currently BLS.
   Ideal staffing minimums is AEMT/EMTP for ALS, EMTB/EMTB for BLS. We do have EMTB fill in at times on ALS, and we do currently have EMTP/EMTP on some ALS units.
   We also will eventually convert the BLS ambulance back to ALS when staffing allows.

2. Please complete the following information about call volumes. (If year is other than calendar, please indicate.) Data is FY 7/01 – 6/30

Table 1 – Five Years Call Volume Data

REQUEST	2013	2014	2015	2016	2017
Total Number of Responses	20,903	20,204	19,249	20,717	**20,514**
Total Number of Transports	17,404	16,679	15,733	16,321	**17,036**
Number of Emergency ALS-1 Transports	9,016	8,015	4,698	5,642	**5,854**
Number of Emergency BLS Transports	204	531	4,122	3,502	**3,559**
Number of Emergency ALS-2 Transports	64	114	128	129	**177**
Total Number of Non-emergency Transports	8,036	8,014	6,610	6,975	**6,817**

Number of Non-emergency BLS Transports	7,968	7,882	6,503	6,881	**6,680**
Number of Non-emergency ALS-1 Transports	68	132	107	94	**127**
Number of Specialty Care Transports	84	5	27	0	**14**
Other Coroner / TNT / MMC	**0/0/292**	**0/0/464**	**105/43/ 422**	**3/67/494**	**148/183/ 292**

If any calls are entered into the "other" column, please describe.
First is Coroner transports, then treat no transport, lastly MMC contract transports

3. Is detailed response transport data available by district/zone, unit, and time of day? If yes, attach a sample report or describe briefly.

Attach: UHU, heat map and Demand Analysis

4. Describe any special geographic, environmental, population centers, or special events, which make providing emergency responses difficult.
   We have multiple rural areas that consist of timely response, New River, Briceville, Windrock ATV park and Andersonville are some of these communities. Oak Ridge National Laboratory (ORNL) and Y-12 are DOE sites that have about eight thousand employees. These sites do have their own EMS, but can become low in major situations. These sites are part of the nuclear production for the US. Oak Ridge city has a "Secret City" festival each summer that brings thousands of people together at one time, also in the same month the city of Clinton has a County Fair. There are many Regatta rowing tournaments in Oak Ridge during the year, this increases driving congestion on one of the main roads to get to Claxton from Oak Ridge.

5. What factors affect service demand levels?
   We handle all hospital discharges, and these are an unknown on the number we may encounter. Highest days are Monday and Friday. Some convalescent calls demand longer time on task. There are many out of county transports done, including some ling distance transports to Nashville. We experience long destination times at many hospitals.

6. Are there seasonal patterns and shifts in established patterns? Our highest average months over the past five years for 911 calls are July, August, January and May. For convalescent it is December, January, April and May. Those two combined January, March, April and May are our highest by average over five years.

7. Describe the service's increase or decrease in annual volume over the past five years. What factors impacted these volume changes? Over the past five years we have increased 6% on 911 calls for service. I do not know what factors have caused this, we had an older age population to start with, that could be a contributing factor. We have seen a 15% decrease on convalescent transports, primary driving factor is improvement on compliance, pre-screening Medicare frequent trip patients before transport occurs, and greater education of hospital on what is medically necessary by CMS rules.

B. RESPONSE TIMES

1. When measuring response times, when does the clock start and stop?

START

Call assigned to an ambulance

STOP

An ALS transport unit arrives on scene

2. Do you measure averages or fractiles? Both

3. What is the schedule or frequency of the reviewing of response time performance? Monthly, as reports are done

4. Provide copies of any reports, which are prepared to monitor response times.
   Attached:
   Response time FY 17

5. What were your service's response times last month for:

   a) Life-threatening emergencies? Not separately tracked, only look at the emergency response calls

   b) Non-life threatening emergencies? Not separately tracked, only look at the emergency response calls

   c) Non-emergencies? Not tracked

   d) Scheduled transports? Not tracked

6. Are there penalties for failing to meet response time compliance (please explain)?

There are not any penalties for failing to meet response time compliance, because there are no set response time requirements.

7. Has there been a trend toward improvement or worsening of response times (please describe)? Response times have been more "stable" then improving or worsening. We may see some movement up or down from month to month but baseline seems to be the same over a longer period of time.

8. What are the most common causes for delays in response times? No units being available to respond, ambulance breakdowns, distance of response

9. What process does the organization utilize to improve response time performance? We have used reporting to the crews their time on task for a period of time. We have seen this decrease the time on task, but have not found that to directly impact response times. This has not been consistent due to the method to run this report and time it takes.

C. DISPATCH

1. Does the entire service area have access through a single designated emergency number (e.g., 911 or 7-digit)?
   The entire service area has access to both Enhanced 9-1-1 and 7 digit numbers for reporting emergencies.

2. Who provides 911 and non-emergent (i.e., non-911/7-digit) call taking and dispatch?

Anderson County 9-1-1 provides services for unincorporated areas of the county and is the dispatching agency for Anderson County EMS countywide. All city agencies provide their own dispatch for fire and law enforcement at their own PSAPs.
Convalescent transport is coordinated by Anderson County EMS by calling the EMS office directly.

3. If there is a primary and secondary PSAP(s), how would you describe coordination between PSAPs?
   In the event that EMS calls are received by a PSAP other than Anderson County 9-1-1, that agency conducts its own caller interrogation, determines its own need for first responder services and then notifies Anderson County 9-1-1 of the request either via radio or telephone. Anderson County 9-1-1 is the sole provider of EMD services in the county, so callers who reach the other PSAPs do not receive EMD services.

4. Do trained and certified emergency medical dispatchers answer emergency medical calls?
   Yes, all dispatch personnel are EMD certified. Personnel in training are not allowed to answer 9-1-1 calls until EMD trained.

5. Do communications personnel perform protocol-based dispatching through a structured interrogation process?
   Yes, call priorities are listed on the EMD cards

6. Do communications personnel provide pre-arrival instructions through a structured process?
   Yes, via APCO EMD cards customized for the agency.

7. Does a trained medical director supervise the communication center?
   The agency does have a medical director who provides indirect supervision of the EMD program.

8. Do you conduct regular case review? If so, how often?
   Dispatch QA / QI policy is currently under revision – answers reflect coming standards

9. If you conduct case review,

   a) How are cases selected?
      Random selection

   b) What is the minimum number per month?
      4 runs per shift, 5 days per week on each of the three shifts = approx 260 reviews per month.

   c) What special case review practices exist (e.g., customer complaint)
      Complaints, cardiac arrests are reviewed as are several law enforcement specific issues

10. Include copies of the standard case review protocol or form and most recent report on case evaluation compliance?
    Current form is attached. New forms under development.

11. How are units dispatched for 9-1-1 calls (e.g., direct dispatch of unit by 9-1-1 dispatchers, the service is notified to dispatch its own units, or other means)?
    Units are dispatched via direct dispatch when the call is received by the county 9-1-1 center. In the event that calls are received by one of the city 9-1-1 centers, information may be relayed via telephone or radio to the county 9-1-1 center where the call will then be direct dispatched.

12. Does the service have access to enhanced 9-1-1 information (i.e., direct display of call back number and address)? Please describe.
    Crews are notified via tone pager from 0800-2000 and called via telephone from 2000-0800.

13. How are crews alerted for calls (i.e. individual pagers, telephone, etc.)?
    Crews are notified via tone pager from 0800-2000 and called via telephone from 2000-0800.

14. How is the need for first response determined and how are they notified and dispatched?
    For calls received by Anderson County 9-1-1, first response is determined by objective criteria on the EMD cards. First response agencies are dispatched via radio for all county agencies and by calling a secondary PSAP via telephone for all city agencies.

    If a call is received by a city PSAP, that agency makes its own determination of whether or not to dispatch first responder agencies. Those determinations are made at the agency level and are not directed by EMD.

15. How is the dispatch center staffed (i.e., number of people by hour of day)?
    Minimum staffing is 3 total dispatchers handling all calls between 0700-2300, minimum staffing is 2 dispatchers between 2300-0700. Typical staffing is 4-5 dispatchers 0700-2300 and 3-4 dispatchers between 2300-0700.

16. What level of certification is required of the dispatch staff (e.g. paramedic, EMT, EMD, other)?
    All dispatch personnel are minimum EMD certified. The center has EMTs and Paramedics on staff, but all must follow EMD guidelines regardless of certification level.

17. Does the 9-1-1 center have computer aided dispatch capability? If so, describe.
    EMS and one for law enforcement. These CAD systems are not integrated and information can not be shared between them.

18. Does the EMS radio system allow for interoperability between system responders (e.g., EMS, fire, law enforcement)? Please describe.
    Yes, agencies may communicate via mutual aid channels on mobile or portable radios available to all personnel.

19. Attach a complete description of dispatch center equipment and communications equipment carried on the ambulances.
    Dispatch equipment includes:
    WinSOMS CAD system for law enforcement use
    CDS CAD system for fire / rescue / EMS use
    GeoConnex GIS mapping system
    West Communications telephone system

VIPER 911 controller
Motorola *** radio system interface

20. In the past three years have there been any instances/time periods where 911 service (being available) experienced an interruption? (If so, please detail). We are not aware of any 911 service interruptions within that time frame with our agency. We have had an instance where another PSAP's 911 calls were routed to us for several hours when their center experienced an outage and we have experienced short duration seven digit outages, but nothing affecting 911 trunks.

D. DEPLOYMENT AND PRODUCTION CAPACITY

1. Are your personnel assigned regular shifts to cover? Yes

2. How is shift scheduling determined (e.g., seniority shift bid)? There is an annual shift bid for the 24 hour ambulances. Day trucks are assigned based on seniority as positions come available. Overtime requests has a procedure that is attached.

3. Attach current schedule and describe patterns and average hours worked per employee per week.
   Six ambulances are on a 24/48 schedule 8am-8am. All are ALS and work 56 hours on average a week.
   One ambulance is on a 12 hour schedule 7am-7pm, 2 on / 2 off, 3 on / 2 off, 2 on / 3 off. This ambulance is ALS and works 42 hours on average a week.
   One ambulance is on a 14 hour schedule 6am-8pm Monday through Saturday, one crew works Monday, Tuesday and Wednesday, the other works Thursday, Friday, Saturday. This ambulance is ALS and works 42 hours a week.
   Two ambulances work 12 hour schedule 8am-8pm, Monday, Wednesday and Friday. One is ALS the other is BLS, they work 36 hours a week.

4. How often are schedules changed? Either at annual shift bid, or as positions become vacant. Crew members are able to "swap" their positions during the year.
   The schedule changes for ambulance start/end times happens seldom. Over the last seven years we have progressed from six 24/48 ALS ambulances and five Monday-Friday BLS ambulances to the schedule listed above. Start times do not have a typical or projected change time and do not respond/react to changes in schedules of transport needs.

5. Do you have an on call schedule for your personnel? No

6. What functions do the on call personnel fulfill? N/A

7. Describe the process in place to manage unscheduled sick call or injury?
   Employee calls in to on duty supervisor. An alert is sent out by an all text to employees to fill the vacancy, at times the supervisor will call individual employees who are not on the all text to offer the opening. If unable to fill one of two things will occur, either the truck is shut down or a current on duty employee may be placed on mandatory overtime for the shift.

8. Are crews based at a specific location or do they "cruise" specified areas? (Enclose a copy of any deployment plan that you utilize.) They are based at a specific location

9. Are vehicles dedicated to one location or are they moved throughout the day? Dedicated to a location, but in periods of low volume they may be moved to "post"

10. Does your service utilize fixed posts or stations? How many? (If so, note on the map the location of posts.) We have six stations for ambulance deployment. When an ambulance goes to post they are sent to a station, unless it is when we are down to one ambulance, then they go to a fixed post.

11. Are there non-transport (quick response) hours? If so, how many per week? On duty supervisor is on 24/7 and is not assigned to a truck. They do provide quick response, additional response at times.

12. How many unit hours are utilized each week? (1 unit hour = 1 unit staffed for one hour) 1,248 are schedule for the week

13. How are the unit hours distributed throughout the day? Please complete the graphs in Attachment 1 for each day of a typical week.

14. What is the average cost per unit hour? (See worksheet - Attachment 2)

15. Do you feel that your service has excess unit hour capacity? Why? We do not feel that there are excess unit hours. Our demand analysis shows we are understaffed to meet the need of current call volume and readiness. Additionally, one of our 24 hour ambulances has consistently exceeded UHU volumes over the past 12 months.

16. Who responds to calls if the service's units are unavailable? How frequently does this occur? Mutual aid may be used if we cannot get an ambulance in service. If supervisor, Deputy Director of Operations or Director are available they may respond. This occurs about 2-3 times a week.

17. Do written mutual aid agreements exist? (Attach copy of all mutual aid agreement(s).) Attach: Roane County contract, first responder agreement, DOE 2001 agreement, 16 county mutual aid agreement , Union County MOA

18. Is there a process to resolve EMS crew delays caused by the receiving facility or unit? (e.g. Emergency Department patient handover delays). There is a process in place to try and relieve an ambulance crew, but it does not always free up an ambulance when used. Attach Call Tree

19. Is hospital diversion an issue? If so, please provide details including any relevant policies or procedures for diversion. It is not an issue.

E. MEDICAL CONTROL

1. Is there a designated Medical Director/Advisor for the service?
   Provide name, affiliations, address, and telephone numbers.
   Meredith Reddington, DO
   Emergency Medicine Physician at Methodist Medical Center – Oak Ridge, TN

Emergency Medicine Physician at Methodist Medical Center – Oak Ridge, TN

2. Provide a copy of the medical director's job description (contract) and salary or describe his or her duties and responsibilities including number of hours per week dedicated to your EMS service. Attach MD contract
   1-2 hours per week reviewing daily "Pass On" reports, and addressing concerns regarding specific calls with local physicians/nurses.

3. Please indicate the qualifications possessed by your service's medical director:

   a) Licensed to Practice Medicine:
      YES

   b) Familiar with local/regional EMS Activity:
      YES

   c) Board certified in Emergency Medicine:
      YES

   d) Actively clinically practicing in Emergency Medicine:
      YES

   e) Completed an EMS fellowship (post-residency):
      NO

   f) Training or significant experience in the practice of out-of-hospital medicine:
      YES

   g) Training or significant experience in the provision of direct (on-line) and indirect (off-line) medical direction:
      NO

h) Training or significant out-of-hospital experience in utilization of emergency patient care equipment, the spectrum of out-of-hospital skills (BLS & ALS), and communication Systems:
YES

i) Completed National Association of EMS Physicians Medical Director's Course or its equivalent:
NO

4. Is the service's medical director the medical director for all communications, first response, and transport providers in the EMS system? Please describe. Our Medical Director is also contracted to be the E911 Medical Director. The first responders fall under EMS and therefore she is their Medical Director as well.

5. Circle the letter indicating each function he or she performs. Using a 1-5 scale (5 high) rate his/her involvement in each area.

a) Administrative consultation 2

b) Training Advisor/Coordinator 1

c) Primary Trainer/Instructor 1

d) Routine incident report 2

e) Regularly reviews tapes/conducts critiques 2

f) Counsels crew members on poor judgment 2

g) Has authority to discipline/suspend personnel 3

h) Reviews system performance data 2

6. Are there written guidelines or protocols for field personnel in ALS situations? Please attach. Attached Clinical Operating Guidelines

7. Are there written guidelines or protocols for field personnel in BLS situations? Please attach. Attached Clinical Operating Guidelines

8. Are there written guidelines or protocols for physicians and/or nurses at the radio control point (base hospital or medical control hospital)? Please attach. None that we are aware of

9. Are regular meetings held between service management and the officials of the receiving institutions? Please describe. No, held as needed.

10. Typically, how does a nurse or physician at a receiving institution deal with what they feel is an inappropriate judgment by a crew?
    At MMC where Dr. Reddington works it has been communicated by her that any physician staff or nurses who have questions or concerns on any patient care provided by Anderson County EMS caregivers can approach her and she will review the chart. Additionally nurses and physicians will question the caregivers directly ideally after completely handing over patient care to the facility and not in front of the patient. Facilities have also contacted management via email or phone call, which causes a QA check, and discussion with the caregiver.

11. Attach a completed sample of the written patient care or trip report (delete patient identification).

12. Who is in charge of the service's internal clinical quality assurance functions?
    Deputy Director of Education oversees clinical quality assurance program

13. Describe in detail the quality assurance activities and provide any written policies or procedures. Please address both internal and external quality assurance programs.
    Anderson County EMS has a CQI team comprised of eight providers that audit tickets that the ePCR system pulls based on set criteria. Anderson County EMS audits the ePCRs internally. All members sign a release/acknowledgement of their duties. The QA system is in our ePCR (ImageTrends). Once an ePCR is selected by a team member to audit they are required to complete the audit of the required elements based on call type and send an internal message to the author of the ePCR should any discussion need to be made. If there is any offenses (poor documentation, protocol deviations, or questionable practices) that message is to include Deputy Director of Education. At any time the ePCR warrants Medical Director review, she is contacted, and she too has access to the program. The Medical Director also reviews all narcotic administrations. Should another Physician contact our Medical Director about a patient care issue/question she will contact the Deputy Director of Education to make them aware, and both will review the report.

14. What events or call types receive 100% or mandatory quality assurance review (e.g. pharmaceutical assisted intubation)?
    Emergency Transports
    Narcotic Administration
    CPAP Usage
    Initial DOA report
    IO Usage
    Mandated Blood Draws

15. Please list all of the regularly monitored clinical performance measures.
    STEMI activation to Methodist Medical Center
    Intubations

Use of Air Transport

16. Please indicate if you track any of the following clinical measures: (If "yes" please list numerical index)

a) In cases were defibrillation is indicated, average time from system contact to first shock.
NO

b) Percentage of patients meeting trauma criteria are transported to a trauma center.
NO

c) Percentage of patients complaining of pain report decrease in the level of pain upon delivery to the emergency department.
NO

d) Percentage of suspected acute coronary syndrome patients received a 12-lead ECG.
NO

e) Percentage of suspected acute coronary syndrome patients received aspirin.
NO

f) Percentage of patients with suspected ST elevation myocardial infarctions that were transported to a hospital with emergency cardiac catheterization capabilities.
NO

g) Percentage of eligible patients who received oxygen.
NO

h) Percentage of unintended esophageal intubations.
NO

i) Utstein Cardiac Arrest Survival Rates.
NO

17. Attach copies of clinical performance measure definitions and the most recent reports.

18. Attach copies of reports from the Cardiac Arrest Registry to Enhance Survival (CARES) for the last three years. Currently not reporting to CARES

F. EQUIPMENT

1. How many ambulances does your service have? 15

2. Attach a list of vehicles and major equipment showing cost, age, mileage, condition, use, and scheduled replacement.

3. Does the service have a preventative maintenance program? Describe. Attach state unit inspection form. Frontline ambulances (Units 1-8) go through an extensive inspection and receive a complete service once per month, frontline units (Units 9 and 10) receive this every other month and Back up units (Units 12-17) are serviced as needed which is every 5000 miles of use.

4. Does the service have in-house mechanical support? Describe. The ambulance service has an employee who is the fleet manager. He coordinates with the county shop on maintenance that is needed to be done; additionally he performs some fixes himself that the county shop does not do. The county motor pool is staffed with mechanics that has multiple ASE certifications.

5. What criteria do you utilize to determine unit-operating costs? We used all cost associated with our fleet. That includes, but is not limited to, fuel, repair cost, parts, tires, mechanic salary payment and insurance.

6. What is the average maintenance cost per vehicle each month? The average maintenance cost per vehicle, per month is $1253.91 for Ambulances and $470.22 for Support Vehicles.

7. What are the average total fleet miles per month? Our average total fleet miles per month for Ambulances are 44,492 and Support Vehicle is 11,471.

8. What is the average cost of vehicle operation per mile? The average cost per mile for Ambulances is $2.37 and for Support Vehicles is $2.44.

9. What expenses are included in the above calculation (#8)? Expenses used to determine the cost per mile were fuel, repair cost, parts, tires, mechanic salary payment and insurance.

10. Describe any major accidents resulting in property damage, injury, or death in the last five years. Reference property loss report from insurance.

11. What is your rate of vehicle failure per 100,000 fleet miles? Unit failures are too numerous to determine a factual rate for every 100,000 miles.

12. What is your rate of vehicle collisions per 100,000 miles? We do not log mileage when a unit is involved in an accident, so there is no way to determine a rate for collisions per 100,000 miles, other than taking our average mileage and the number of accidents on the insurance report. Not sure that is what is being asked here though?

G. PURCHASING & INVENTORIES

1. Who is responsible for the purchasing of medical supplies? Medical equipment? Major assets? The Deputy Director of Support Services oversees medical supplies and equipment. This is a recent change for our organization. Vehicle purchases are handled by the Director, with additional help from Deputy Director of Operations and the Fleet Manager. All decisions for major purchases are finalized by the Director.

2. What is the company's policy on carrying inventories of regularly used materials or supplies? There is a State rule on what equipment is to be on the ambulances. Recently removed supply stock at the substations, have moved to a central supply.

3. Describe your supply process and how units receive and replace supplies. Units perform vehicle inspection daily at the beginning of their shift. They report to the on duty supervisor what supplies they need and that is either delivered to them or they come to central supply to get them. An email is also sent documenting the supply request, this email is sent to the shift supervisor and the Deputy Director of Support Services.

4. Briefly describe the procurement procedures that are followed (i.e. authorized requisitions, purchase orders, receiving and supplier payment). Provide copies of the forms utilized. There are annual bids sent out for medical supplies. Based on those bids we will issue purchase orders as needed. Usually we get a blanket

purchase order that will handle a couple months of purchases, when it gets close to being low we request a new purchase order. All purchase orders are requested from the purchasing department, who verifies with accounts and budgets that we have the money budgeted for what is requested, and that the company we are buying from is an approved vendor.

5. Are any medical supplies or pharmaceuticals exchanged with hospitals? If so, describe items and process. NO

6. What is the total dollar value of medical supply inventories? Not readily available

7. How are medical supplies on units and in storage areas accounted for? Ambulances perform a daily vehicle inspection on all equipment during periods of operation. Standby ambulances are inspected at least every 72 hours. All ambulances are to be housed indoors. Storage is a secured facility with only select individuals having access. When ambulances get restock it is documented what is being requested and what is being delivered. There is a daily visual inspection done at central supply, additionally there is a quarterly inventory audit that will be done going forward.

8. What methods are used to account for drugs and medications? Describe. Drugs and medications are accounted for the same way as listed above. Narcotics are secured in a safe that is secured by the on duty supervisor. The narcotics are only on manned ambulances, no reserve ambulances maintain a stock of narcotics. Attach Narcotic policy.

H. INTERAGENCY COORDINATION

1. Does your service interact with first responders from other public safety agencies? If so, describe. There are monthly Fire Commission meetings that EMS participates in. Other than this it would be an as needed situation.

2. List all first responder agencies in the response area? Anderson County Rescue Squad, Andersonville Volunteer Fire Department, Briceville Volunteer Fire Department, Claxton Volunteer Fire Department, Clinton Fire Department, Marlow Volunteer Fire Department, Medford Volunteer Fire Department, Norris Fire Department, Oak Ridge Fire Department, Oliver Spring Fire Department and Rocky Top Fire Department

3. What is the level of training for first responders (e.g., first responder, EMT, ALS)? EMR, EMTB, AEMT, Paramedic, CCEMTP

4. Are first responders part of a coordinated response system & medically supervised by a single system medical director? They are part of a fragmented response system, we all fall under the same Medical Director.

5. What are the response time expectations for first responder agencies? Are they externally monitored? They are not set or externally monitored by Anderson County EMS. Oliver Springs Fire Department has set average response times and reports them to their city council. Briceville does not have set response times. The other agencies have not responded to this question. (updated 9-13-2017)

6. Are all primary first response units equipped with: AEDs? Oxygen? Epi-Pens? Anderson County EMS provides supplies to each first response agency in Anderson County. Those supplies are used to stock their agencies first response units. This includes oxygen, but does not include AEDs or Epi-Pens. AEDs are

provided by the agency themselves, but AED batteries and pads are provided by Anderson County EMS. If they can give Epi, then it is provided in an ampule/vial for them to draw up and administer.

7. What types of joint training activities occur, if any, between your service and other agencies? EMS organized training is open to all first responders, but there are seldom set trainings that is multi-agency coordinated.

8. Is there a system-wide disaster plan in place? Anderson County EMA has a Basic Emergency Operations Plan (BEOP), for hazard mitigation that address Emergency Support Function (ESF) for all potential responders in an emergency.

9. How frequently are disaster drills conducted? DOE plants have annual drills that do include EMS, but not all first responders. There was a table-top exercise that was recently done to include all first responder agencies.

III. HUMAN RESOURCES

A. PERSONNEL

1. Provide a list of employees by position including, certification level, years with service, full or part-time status, and approximate annual wage or salary cost of each.
   Attachment

2. What percentage of total wages are benefits? Describe benefits. Benefits are 25% of total wages. This covers Social Security, retirement, short-term disability, workers compensation, Medicare, medical/vision insurance, dental insurance and life insurance.

3. Comment, describe, or show where in other documents or attachments, information on the following items may be found:

   a) Employment, recruiting, and personnel policies and procedures Attach SOPs, Policies, new hire packet

   b) Accident frequency and safety record
      Attach report from insurance

   c) Workers compensation claims
      Attach report from insurance

   d) Medical problems and sick leave frequency Sick time is calculated but not monitored. When frequent use is called into question is when we will take a look at it.

e) On-call scheduling and pay rates N/A

f) Wage and salary administration policies N/A

g) Any unfilled positions: One AEMT position on a 24/48 ambulance.

4. Describe the trend over the past three years in these elements of the organization: (separate pages will be required)

a) Absenteeism, accidents, grievances, and overtime
Absenteeism: Sick leave was down last year, and the second lowest it has been since 2013.
2013: 5,111
2014: 3,777.5
2015: 5,146.25
2016: 5,192
2017: 4,358.75
Personal leave has been consistent to run between 1,000-1,100 each year, but was the lowest in each year going back to 2013.
2013: 1,144
2014: 1,061
2015: 1,248
2016: 1,126
2017: 996.25
Vacation leave was down from the year before.
2013: 4,504.5
2014: 4,766.25
2015: 4,998
2016: 5,532.25
2017: 5,047
Overtime: This has been up due to vacancies. Last year we spent about $50,000 less on overtime than the year before.
Accidents: See workers comp document

b) Staff and management turnover. Staff turnover in the past three years has been high. Tennessee is experiencing a shortage of EMTs and Medics since the rule changes went into effect. Tennessee changed away from EMT-IV to EMTB, AEMT. EMT-IV was one semester of college, to become an AEMT it is now two semesters. State rules did not accommodate for EMTBs to be on an ALS ambulance, and enrollment at the colleges have decreased.

Other agencies offering higher pay, or other opportunities has also caused some turnover.

Additionally we made a change from an ALS/BLS service to an all ALS. This has caused some turnover as there are some Paramedics that did not want to increase their convalescent call volume.

Management turnover is very low, other than eliminating a position, the only other change was due to termination.

5. Are personnel affiliated with a labor organization? If so, which one? Please attach agreement. No

6. Are any formal charges pending before federal/state labor agencies? Violation of EEOC charge made by former EMS employee against the HR department, not EMS.

B. TRAINING

1. What are the training requirements for each position by the organization?
EMTB - State License for current level, BLS CPR, EVOC, Vanessa K. Free, PHTLS or ITLS, EVE, Domestic Violence, HIPAA, IV Pumps, SIDS and 30 hours continuing education.

AEMT – State License for current level, BLS CPR, EVOC, Vanessa K. Free, PHTLS or ITLS, EVE, Domestic Violence, HIPAA, IV Pumps, SIDS and 30 hours continuing education.

EMTP - State License for current level, BLS CPR, ACLS, PALS, EVOC, Vanessa K. Free, PHTLS or ITLS, EVE, Domestic Violence, HIPAA, IV Pumps, SIDS and 30 hours continuing education.

CCEMTP - State License for current level, BLS CPR, ACLS, PALS, EVOC, Vanessa K. Free, PHTLS or ITLS, EVE, Domestic Violence, HIPAA, IV Pumps, SIDS and 30 hours continuing education.

2. Is this training required before employment, on the job?
   Training required before consideration –
   EMTB/AEMT: State License for current level, BLS CPR.
   EMTP/CCEMTP: State License for current level, BLS CPR, ACLS, PALS

3. What is the number of EMT training hours required for licensure? Who trains?
   Requirements for EMT: 20 hours as listed
   13 Cardiac, Medical, Trauma
   5 Pediatric
   2 Prepatory

   Required training is taught by Anderson County EMS

4. Is there an intermediate level of licensure? (i.e. EMT-I, cardiac tech) What is the number of hours required for licensure? Who trains?
   Yes, Advanced EMT
   Requirements are 25 hours as listed below:
   15 Cardiac, Medical, Trauma
   8 Pediatric
   2 Prepatory
   Required training is taught by Anderson County EMS

5. What is the number of EMT-paramedic training hours required for licensure? Who trains?
   Requirements for EMTP is 32 hours:
   21 Cardiac, Medical, Trauma
   8 Pediatric
   3 Prepatory

   Required training is taught by Anderson County EMS

6. Who trains most of the organization's personnel? (college, hospital, etc.)
   Training is done in house by Anderson County EMS Personnel or outside instructors brought in.

7. What type of pre-employment screening is utilized for prospective employees?
   TBI/FBI fingerprint background check
   Medical physical
   Drug test
   DMV record check
   Employment verification
   Assessment center: involves four stations – physical ability test, hands on scenario, written test and panel interview

8. Describe any formal or informal job orientation program utilized.
   Anderson County EMS Academy is usually a three week orientation program (schedule is attached). They then complete nine orientation rides with an FTO. First three rides are with initial FTO, next three with a second FTO, last three are with initial FTO. Daily evaluations are conducted, and a final evaluation is completed.

9. Who is responsible for the in-house continuing education and training?
   Bobbi Jo Henderson is over all education, Carrissa Keathley is our in-service coordinator and Janie New is our Instructor Coordinator.

10. How are employees compensated for continuing education?
    Employees are paid for their time attending the courses and in-services taught by Anderson County EMS.

11. Describe any in-service training done by or required by the service or regulatory agency.
    In-service training is geared toward requirements by NREMT and the State of Tennessee. Additionally case studies, introduction to new equipment and protocols.
    State of Tennessee requires: Domestic Violence, SIDS, pediatrics and bi-annual RSI/Facilitated airway training. These are covered at mandatory in-service training. Anderson County EMS schedules five, six hour in-services annually. Each in-service is offered in three consecutive days.

    HIPAA and IV Pumps are also covered annually.

    Personnel have the ability to take the courses listed below, which are taught by Anderson County EMS instructors.

    BLS CPR
    ACLS
    PALS
    PEARS
    EVOC
    VKF
    EVE
    AMLS
    EPC
    PHTLS
    GEMS
    AHDS
    EMS Safety
    EVOS
    SIDS

12. Are formal training records maintained? If so, attach a sample. Partial Sample attached, there is also a copy of certain documents that go into a training file, such as copies of all certificates, state licensure, driver license, physical, copy of all ceu certificates, skills check off sheets and answer sheets from in-service training.

a) Do you have a required number of CEU's? Do you track compliance?
   Yes, State of Tennessee requires 16 hours. Compliance is subject to be audited by State at any time.
b) Do you track skills? (e.g. intubations, IV starts).
   Yes
c) Have you conducted National Incident Management System (NIMS) training and/or fully compliant with the NIMS Implementation?
   ICS 100, 200, 700 and 800 are required for all caregivers. Supervisors will also have 300 and 400.

IV. ORGANIZATIONAL STRUCTURE AND MANAGEMENT

A. ORGANIZATION

1. Attach or describe the formal and informal organizational charts. Describe the informal reporting relationships, which do not directly conform to the formal organizational chart. See attached document.

B. MANAGEMENT

1. In a short paragraph describe each of the key management functions, the names of persons in those positions, accredited degrees they have earned, management training attended, and length of time in the position. See attached document.

2. Have there been any recent losses of management personnel? Why? Yes, we eliminated the supply manager position, this individual went back on the ambulance full time and those duties are now being done by the Deputy Director of Support Services. This was done as a cost savings.

3. How many employees resigned voluntarily last year? How many were fired? Briefly describe the reasons for the resignations/terminations. How does this compare with the five year trend?

   In calendar year 2016 we had 19 resignations and 6 terminations. This is both full time and part time.
   Full time resignation reasons:
   Three left for another EMS job (one for a slower service as they were going back to school, one for more money, one no longer liked working here)
   One moved to another state due to fiancé getting a teaching job
   One went to work in the ED at the trauma center, no longer liked working EMS

One did not complete orientation, but ended up not wanting to leave their other EMS job
One left to go back to school full time
Two left the profession
One left due to health reasons, unable to work in the sunlight
One left to accept a job teaching the deaf
One left for a supervisor position with another EMS agency
One left due to working two full time positions with EMS and Fire
One left to return to work in law enforcement

Full time termination reasons:
One was terminated for failure to report to work, this was during them working out a two week notice, which they were going back to their previous EMS job after less than a year with Anderson County EMS

Part time resignation reasons:
Four left due to not being able to fulfill training requirements
One left due to moving to Florida
One left due to completing nursing degree and wanting to work solely in nursing

Part time termination reasons:
Four were terminated due to failure to meet training requirements

This is on the high end of the five year trend except terminations that is on the low end.

V. FINANCIAL CONSIDERATIONS

A. FINANCE AND ACCOUNTING

QUESTIONS 1 - 14 MAY NEED TO BE ANSWERED BY THE FINANCE AND BILLING DEPARTMENTS.

1. Who functions as the Chief Financial Officer for the service? Anderson County Finance Director Natalie Erb

2. What is the service's fiscal year? July 1 – June 30

3. Send copies of:

   a) Financial statements for the past five years attached document

   b) The most recent financial reports attached document

   c) A chart of accounts (if different from the financial statements) and a brief explanation of accounting practices. attached document

   d) Monthly reports of actual revenues and expenditures for the past five years. attached document

4. Enclose a copy of the organization's year end detailed budget for revenues and expenditures for this current fiscal year and last five years. attached document

5. Describe the insurance the service has in effect in terms of type, extent of coverage, and deductibles.

EMS is covered by the same Worker's Comp, Property, and Liability policies as the rest of the County's services and operations. See attachments in "Insurance Policies" folder for limits and deductibles.

Cost Allocation for Worker's Comp

For FY 2017 and earlier, allocation of premium is based on % of Total Payroll and worker classification rating from Tennessee Risk Management Trust.
Beginning FY 2018, allocation will be made on average % of Total Claims over the last 5 years.

Cost Allocation for Property and Liability

No organizational memory of the historical allocation basis. Any increase in Total County Premium is applied to County account code of "Other G&A".

6. Are there any charges pending against the organization by any federal or state agency? No

7. Are there any civil proceedings or lawsuits pending or anticipated? No

8. Is the organization in compliance with environmental, equal opportunity employment, and OSHA requirements? To the best of our knowledge we are

9. Does your organization offer a subscription or membership program? If so please detail program including costs, revenues, number of members, etc. We do not, have looked at doing this but have not pursued it with County Commission

B. BILLING AND COLLECTION

1. If billing is outsourced, provide the contact information for the company including the account representative/manager responsible for your account. How long has this company handled billing for the agency? Digitech does our EMS billing, Cathy Tenzyk (www.ctenzyk@digitechcomputer.com) is the point of contact for this audit. Digitech has been billing for us since July 1, 2016. Prior to this it was AMB for the 15/16 FY.

2. Comment on any trends in revenues including net income versus total billings. We have seen a decline over the years; specifically with the number of insurance transports we have dropping and the number of Medicaid transports increasing. This has reflected a decrease in net income versus total billings.

3. What were gross patient charges: Net patient collections:

a)	Year ending 6/30/17 (Digitech)	a. $14,621,922.36 / $4,939,595.30 a. $204,549.82 / $582,014.12 (AMB)
b)	Year ending 6/30/16	b. $13,979,568.56 / $5,108,876.07
c)	Year ending 6/30/15	c. $11,550,506.56 / $4,540,102.03
d)	Year ending 6/30/14	d. $10,448,065.00 / $5,166,905.95
e)	Year ending 6/30/13	e. $11,091,000.00 / $5,336,338.45
f)	This fiscal year to date? 8/23/17 for July 2017)	f. $1,387,970.66 / $256,373.75 (As of

g) Note other income
(i.e. General Revenue funds)?
If subsidies are involved, describe.
Contract with Roane County is $59,000 a year, paid quarterly

Contract with MMC for "on-site" transports is under current contract negotiation. Was being done for ~$178 per transport. Projected increase to Medicare Fee Schedule rate.
Training generates about $2,500 - $7,500 a year

4. What is the <u>average</u> charge per patient?

Table 1 – Average Charge FYE 2017

	Gross Base Charge	Net Base Charge	Gross Mileage Charge	Net Mileage Charge
ALS 2	**$1,100.00**	**$691.79**	**$198.68**	**$127.47**
ALS Emergency	**$850.47**	**$443.24**	**$183.72**	**$98.37**
ALS Non-Emergency	**$650.00**	**$315.26**	**$526.84**	**$320.92**
BLS Emergency	**$750.80**	**$360.07**	**$146.82**	**$72.64**
BLS Non-Emergency	**$550.40**	**$207.50**	**$187.86**	**$76.77**
Coroner Transport	**$108.35**	**$56.54**	**$_____**	**$_____**
SCT Non-Emergency	**$1,192.38**	**$574.41**	**$329.03**	**$141.93**
TNT	**$75.00**	**$63.70**	**$_____**	**$_____**
SCT Emergency	**$1,266.67**	**$629.46**	**$258.44**	**$120.04**
ALS2 Non-Emergency	**$1,100.00**	**$598.96**	**$4,420.47**	**$4,289.63**

5. Patient mix:

a) Self pay _____%
   - FY 18 10%
   - FY 17 7%
   - FY 16 6.74%
   - FY 15 6.9%
   - FY 14 5.92%
   - FY 13 5.36%

b) Insurance _____%
   - FY 18 11%
   - FY 17 9%
   - FY 16 14.76%
   - FY 15 35.39%
   - FY 14 24.11%
   - FY 13 24.36%

c) Medicare _____%

FY 18 60%
FY 17 58%
FY 16 65.32%
FY 15 39.99%
FY 14 52.05%
FY 13 52.36%

d) Medicaid _____%
FY 18 17%
FY 17 23%
FY 16 12.21%
FY 15 17.36%
FY 14 17.36%
FY 13 17.77%

e) Facility Contracts _____%
FY 18
FY 17
FY 16 0.97%
FY 15 0.36%
FY 14 0.56%
FY 13 0.15%

f) Other indigent _____%

g) Other

FY 18 3%
FY 17 4%

h) Average amount paid per trip - insurance? $_____
FY 18 $484.67
FY 17 $828.85
FY 16 $487.04
FY 15 $346.73

FY 14 $390.07
FY 13 $414.50

i) Average amount paid per trip - Medicare? $_____

FY 18 $237.18
FY 17 $269.07
FY 16 $289.53
FY 15 $314.52
FY 14 $323.34
FY 13 $330.49

j) Average amount paid per trip - Medicaid? $_____

FY 18 $114.65
FY 17 $164.65
FY 16 $157.87
FY 15 $187.33
FY 14 $176.09
FY 13 $170.14

6. What is the service's collection rate?

a) For the last three months?
Overall Gross Collection Percentage: 27%
Overall Net Collection Percentage: 55%

b) Last fiscal year?
Overall Gross Collection Percentage: 34%
Overall Net Collection Percentage: 72%

c) How is the collection rate calculated? Describe in detail.
Gross Collection Percentage = Total Paid / Total Gross Charge
Net Collection Percentage = Total Paid / Total Net Charge

7. Is the collection rate available by: (If available, provide examples)

a) Major insurers?
Please See "Anderson – AS Overall Summary by FC - 2017

b) By geographic area / district?

c) By hospital of origin (transfers and discharges)?

8. What are the accounts receivable aging and value? (Please provide reports)
Please see "Anderson – AR by FC Aged by Sale Date – Sales thru 201707 as of 201707"

9. What are the service's days in accounts receivable? (Average daily charges divided into the total accounts receivable)
DSO: 113 (Data obtained from July 2017 Roll Forward)

10. What is the service's estimate of contractual allowances for:

a) Medicare?
FY 17: $4,598,039.69
FY 18: $542,712.25

b) Medicaid?
FY 17: $2,803,001.90
FY 18: $153,783.42

11. Complete the following tables for each of the last five years:

Table 2 – 2013 Financial Information

Month	Total Charges	Allowances & Adjustments	Cash Collections
January	$973,970.00	$1,512,672.03	**$452,359.81**
February	$875,300.00	$314,665.13	**$412,189.89**
March	$908,705.00	$517,863.54	**$476,572.81**
April	$897,790.00	$481,855.37	**$438,814.22**
May	$1,012,720.00	$1,115,369.30	**$456,789.21**
June	$841,425.00	$861,878.74	**$275,711.52**
July	$905,615.00	$572,813.56	**$635,593.16**
August	$839,475.00	$374,867.26	**$449,567.17**
September	$813,310.00	$328,599.96	**$398,466.12**
October	$858,440.00	$397,450.26	**$461,515.82**
November	$818,045.00	$332,442.88	**$430,105.39**
December	**$858,060.00**	**$393,897.96**	**$426,295.51**

Table 3 –2014 Financial Information

Month	Total Charges	Allowances & Adjustments	Cash Collections
January	$924,750.00	$462,451.28	**$426,895.44**
February	$880,590.00	$334,781.01	**$419,863.80**
March	$870,560.00	$485,694.10	**$418,712.09**
April	$930,795.00	$313,775.17	**$329,324.23**
May	$922,245.00	$305,207.33	**$355,796.25**
June	$826,180.00	$450,430.62	**$414,770.97**
July	$810,190.00	$462,783.25	**$437,362.21**
August	$841,978.00	$244,077.55	**$339,978.81**
September	$758,201.00	$232,345.06	**$341,830.32**
October	$791,883.00	$1,311,360.90	**$435,018.97**

November	$733,166.00	$381,861.88	**$333,135.10**
December	**$798,205.00**	**$347,727.51**	**$357,981.43**

Table 4 – 2015 Financial Information

Month	Total Charges	Allowances & Adjustments	Cash Collections
January	$1,212,887.55	$447,922.58	**$396,247.75**
February	$1,089,146.98	$521,542.51	**$393,813.60**
March	$1,167,490.82	$566,780.49	**$356,060.53**
April	$1,109,152.11	$516,686.03	**$411,748.77**
May	$1,157,298.35	$959,839.87	**$505,489.49**
June	$1,080,907.75	$400,171.65	**$290,612.37**
July	$1,010,845.58	$614,604.98	**$417,624.17**
August	$1,279,637.23	$672,362.94	**$467,785.43**
September	$1,199,549.65	$638,179.08	**$497,463.74**
October	$1,028,388.37	$653,745.70	**$419,618.00**
November	$1,138,335.85	$896,321.31	**$393,252.12**
December	**$1,389,659.94**	**$583,854.17**	**$398,791.74**

Table 5 – 2016 Financial Information

Month	Total Charges	Allowances & Adjustments	Cash Collections
January	$1,156,593.87	$510,016.87	**$308,468.96**
February	$958,852.83	$703,760.47	**$393,226.06**
March	$1,040,430.15	$835,614.03	**$478,136.86**
April	$1,019,103.10	$1,142,332.35	**$374,711.86**
May	$1,529,825.27	$1,448,186.17	**$616,097.20**
June	$1,228,346.72	$581,593.25	**$385,355.39**
July	1,291,884.75 210,567.05 (AMB)	691,707.26 $268,357.05 (AMB)	**444,457.08** **$186,922.72(AMB)**

August	1,260,298.17 $4,158.64 (AMB)	695,563.42 $396,478.19 (AMB)	**435,655.82** **$244,945.32 (AMB)**
September	1,174,690.57 $1,057.91 (AMB)	630,213.32 $138,912.27 (AMB)	**423,428.55** **$51,322.21 (AMB)**
October	1,214,077.69 $1,102.50 (AMB)	633,815.09 $987,325.50 (AMB)	**447,379.33** **$110,227.12 (AMB)**
November	1,161,978.03 $301.82 (AMB)	623,128.69 $48,141.90 (AMB)	**399,025.61** **$22,954.59 (AMB)**
December	1,211,348.20	636,611.59	**437,486.99**

Table 6 – 2017 (to date) Financial Information

Month	Total Charges	Allowances & Adjustments	Cash Collections
January	1,267,658.73	690,828.78	**411,859.51**
February	1,225,024.20	668,323.72	**413,563.58**
March	1,318,163.96	695,205.80	**413,875.36**
April	1,159,447.91	604,815.79	**374,835.94**
May	1,222,474.27	646,279.12	**411,230.56**
June	1,114,851.23	552,745.63	**343,034.25**
July			
August			
September			
October			
November			
December			

12. Has the service undergone a Medicare or Medicaid audit in the last five years? If so, when and what were the results? Yes, we were under an A0427 and A0425 pre-pay review audit from April 2014 until July 2016. Documents attached in regards to this.

13. Are billing activities automated? If yes, what type hardware and software? Provide a list or samples of all significant operational and accounting reports that are available with this system.

14. Describe (in days) the current billing and collection procedures. If a written description exists, attach, if not diagram. When the PCR is completed it must be screened by the in-house Billing Manager before it is sent to Digitech. Depending on the volume, weekends and holidays this can take several days. Typically by the end of the week it is all caught up for that week. Our Billing Manager works to keep it up to date, to include doing some work on weekends, holidays and on vacation (none of which is required). Once the PCR has been screened it is sent to Digitech for billing. No money is received by Digitech, it is all electronically deposited in Anderson County EMS Suntrust account, or is delivered to Anderson County EMS and we place it in our Suntrust account. See attached procedure

    Additionally each day we upload our daily convalescent transport schedule to include our prior authorization numbers, and medical necessities. These are uploaded to Digitech's secure server. Any bank deposits done by us are also uploaded to Digitech for reconciliation of records.

15. Identify the number of people and the amount of time dedicated to internal billing duties. Please provide contact information. We have one person dedicated to in house billing duties (Tammy Leopper). She screens all of 911 and discharge transport PCRs before uploaded and sent to Digitech for billing. She is checking for accurate dates, times, insurance information (from hospital face sheet digitally attached), and scans through the narratives to see if completed. She works with in-house billing calls and complaints. She works with facilities that call with questions. She bills Methodist Medical Center monthly for the contracted transports. Additionally she is part of three people who process any payments received on site or mailed directly. Almost all of her time is dedicated here. She may help with other items, but most of her time is spent on these duties.

16. Does the service use in-house collection activities? (i.e. letters, phone, other) Not done on site at Anderson County EMS.

17. Does the service use an outside collection agency? If yes, of those accounts turned, what percentage is collected? If no, why not? We use Wakefield (formerly Revenue Recovery) Report attached

18. How are billing complaints handled? On site with Anderson County EMS all billing complaints are dealt with by the in-house billing manager. She has access to the billing system to look up all information in regards to the bill. She is able to explain about what insurance has, or has not, paid. Billing complaints that go to Digitech are not sent to us, they are the front line on these complaints and deal with them. They do not inform us if a complaint has been filed, unless it is a complaint in regards to something other than the bill, then they would advise the caller to call us directly.

19. What are current fees/charges for service? To whom is the invoice sent? (Attach a list including base rates and add-ons.) For the past ten years, provide the current fee schedules along with the current fee schedule and date of adoption. Current and Past Fees: Please see "Anderson – Rates" spreadsheet. Invoices are sent to all payer groups

20. Enclose a copy of the service's Medicare rate allowable rates for each level of service and mileage. Already have this per the kickoff meeting.

21. Has the organization developed a compliance program? Describe Anderson County EMS has a compliance program, see attached.

22. Does the organization have a written billing and collection procedure manual? We do not have a written procedure, but all accounts being sent to collections from Digitech must go through our Billing Manager. Here she screens them to ensure the billing process has been followed before sending to the collection agency.

23. Average mileage for transports (total miles charged divided by total number of transports). Average Loaded Miles per Transport: 12.2

24. What Exchange Programs (Affordable Care Act) cover Anderson County? Have any of the Exchange Programs changed or pulled out in the past two years. If so, describe. Unknown