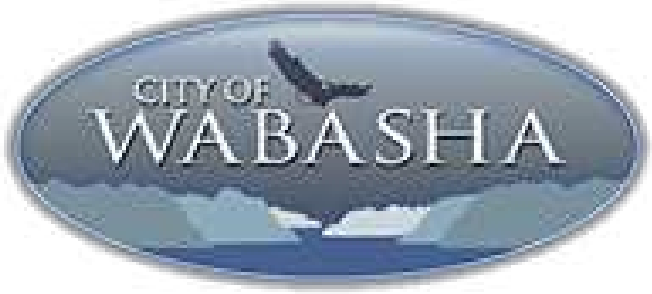

WABASHA AMBULANCE SERVICE ASSESSMENT

Comprehensive Assessment

Abstract

This report is the summary of findings as well as future considerations for the City of Wabasha as it relates to operating its ambulance service

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INTRODUCTION

Purpose and Intent

The purpose of this document is to provide the City of Wabasha leaders with the results and considerations from the performance of a comprehensive assessment of its municipally owned and operated ambulance service. The assessment was performed by a core group of leadership staff from Tri-State Regional Ambulance, Inc. (TSRA), a subsidiary of Gundersen Health System. This assessment includes a broad exploration of various operating functions as well as the analysis of the financial components of Wabasha Ambulance Service; hereafter referred to as "WAS." The accuracy and depth of this analysis is dependent on TSRA obtaining requested information from multiple WAS stakeholders. These stakeholders include, at a minimum, ambulance service employees and volunteer staff, the ambulance service manager, the ambulance service billing company, the City of Wabasha administrative and accounting staff, and the MN EMSRB.

Project Background and Description

This project involves analyzing the overall financial and operational health of the Wabasha Ambulance Service as requested by the City of Wabasha. Tri-State Regional Ambulance, Inc. will be functioning as an independent contractor in service to the city.

The outcome quality of this project will be dependent upon obtaining accurate and timely operational, financial information from the ambulance service, the City and any applicable third-party vendors or contractors. The project's outcome will be for Tri-State Regional Ambulance, Inc. to provide the city with a comprehensive report of findings resulting from the analysis of provided information and data. The analysis will also be abridged and provide suggestions on areas which could be improved and highlight areas of presently robust performance.

Project Scope

This project's scope will be to analyze the financial and operational health of the Wabasha Ambulance Service and to provide a report including findings and recommendations for improvement.

WAS Requirements

To provide a proper review and analysis of the Wabasha Ambulance Service, at a minimum, WAS shall provide:

- An informed and willing set of stakeholders associated with the ambulance service.
- Timely responses to data and information requests.
- An understanding that the outcome of this analysis, in large part is dependent upon the quality of the data and information provided.
- Access to the individuals or staff who may be requested to be interviewed by TSRA.
- Support and responsiveness from city leaders.

The deliverables of this project will be a thorough analysis and recommendations (where applicable) as outlined below:

- Revenue Cycle (Billing)
    - Billing process efficiency (from caregiver to payment)
    - Contracts (if any) with insurers
    - Other revenue sources
    - Collection processes after billing
    - Payer mix summary
    - Billing rate review
- Financial aspect of overall operations
    - Review of financial statements
    - Review of equipment and vehicle costs
    - Review of operational efficiencies
    - Analysis of staff scheduling costs and needs
- Fiscal impact of salary and benefits
    - Review of wage and salary costs and comparison to market
    - Review of fringe benefit costs
- Staff development and training cost analysis
    - Education labor costs
    - Costs of staff labor for education
- Staff recruitment and retention
    - A SWOT analysis with staff involvement
    - Recommendations for future
- Financial review of community support initiatives
    - Fundraising
    - Contributions
    - Community goodwill
- Budgetary impact of recruitment and retention of ambulance service personnel
    - Cost of turnover
- Explore Operational Models/Collaboration Options

Specific Exclusions from Scope

This scope will concentrate on the financial and operational aspects of the Wabasha Ambulance Service.

This report is not legal advice and explicitly not included in this analysis are the following:

- Clinical and medical practices, protocols, or performance.
- Forensic auditing or other analysis of general city accounting practices
- Auditing of or review of coding of claims and claim submissions to any payer
- Compliance of procedures and practices as they relate to the Health Insurance Portability and Accountability Act (HIPAA) and dissemination of Protected Health Information (PHI)
- Compliance with various government payer regulatory and enrollment requirements
- Compliance with wage and hour regulations or FLSA laws
- Compliance with the Affordable Care Act rules and regulations
- Compliance with PERA (Public Employees Retirement Association) or other pertinent retirement plans or post-employment benefits
- Compliance with other local, state, or federal regulations or laws

The revenue (income) aspects of WAS will be explored first, and suggestions will be discussed. Following the revenue collection process of WAS, the expense aspect of the operation will be explored in as much detail as possible based upon the information provided to us. The closing section will focus on the results of staff interviews and areas for improvement related to staffing and culture.

This document's creators strive to use factual-based comparisons and comments. When the consultants are unable to completely quantify recommendations based upon provided facts and/or data, terms such "consider" and "may" will be used. It should be noted that no two ambulance services are alike, and each can possess their own unique challenges.

Of special note is the fact that billing processes and patient revenue data prior to October of 2021 are limited due to a change in billing companies.

ABOUT WABASHA

Wabasha is a city in southeastern Minnesota along the Mississippi River. The city has a population of around 2,564 people, according to the United States Census Bureau's 2019 American Community Survey. The median household income in Wabasha is $51,875, and the per capita income is $22,867. The median age in Wabasha is 48.1 years old.

The city has a rich history, dating back to the early 1800s when it was a trading post for the Mdewakanton Sioux and Ojibwe tribes. The city was officially incorporated in 1858 and named after Chief Wabasha of the Sioux tribe.

Wabasha's location on the Mississippi River made it a hub for transportation and commerce in the 19th century. The city was a major stop for steamboats, and it was also a center for logging and milling. The city's economy diversified in the 20th century, with industries such as manufacturing, retail trade, and healthcare.

The city is home to several popular attractions, including:

- The Wabasha Street Caves, a network of limestone caves used for various purposes throughout history, including as a speakeasy during Prohibition.
- The National Eagle Center, a facility dedicated to the education and conservation of eagles and other birds of prey.
- The Wabasha County Historical Society, which has a collection of artifacts and exhibits that tell the story of the city's history.
- The Great River Road, a scenic byway that runs along the Mississippi River and offers beautiful views of the river and the surrounding bluffs.

The largest employers in the area include Wabasha Kellogg Public Schools, Gundersen St. Elizabeth's Hospital, Wabasha Care Center, and the City of Wabasha. The city also has a diverse economy, with other industries like agriculture and services which also contribute to the economy.

Wabasha is also a wonderful place for outdoor activities, with various parks and trails that offer hiking, biking, and bird watching opportunities. The city also has a strong community spirit, with many festivals and events throughout the year that bring people together.

Overall, Wabasha is a small city with a rich history and a diverse economy, situated in a beautiful location along the Mississippi River. It offers a variety of outdoor and cultural activities, as well as opportunities for education and employment.

BILLING AND REVENUE CYCLE

Overview

Ambulance services typically rely on fee-for-service (FFS) funding, i.e., an ambulance transport is provided and the patient or patient's payer (insurance, Medicare, Medicaid, etc.) is invoiced (billed) for that service. Because the patient and/or their payer are billed, no money is exchanged at the time of the ambulance response and the service is included as a receivable for the ambulance service.

Ambulance services, as well as most of healthcare accounting practices use an accrual basis for their financial accounting rather than a cash basis. After the ambulance transport is provided, that patient is in "debt" to the ambulance service for the balance of the charges. That expected receivable amount is then included as part of the current month's financial reports and statements. The primary purpose of utilizing an accrual basis for accounting instead of a cash basis, is that in health care it is the norm for receivables to be paid in 30 to 90 days from the date of service with some payments taking much longer. Accrual accounting supplies a much timelier understanding of the expected receivables as compared to a cash accounting method where revenue is only reported when it is received, rather than when the service is provided. When an entity uses an accrued accounting method, it is common for the outstanding accounts to be shown on the balance sheet as part of "Accounts Receivable" asset.

When an ambulance operation is but a portion of a larger financial unit, such as the City of Wabasha, the accounting method used by the greater entity is typically chosen. In this case, the City of Wabasha adheres to Minnesota recommended financial practices, which are comparable to cash-based accounting. Before October 2021, the previous billing vendor did not use an organized method of tracking total ambulance receivables or account aging above the individual account level.

Regardless of accounting practices on the back end, the following information explains and analyzes this process of recovering the incurred debt, also known as the accounts receivable (AR).

The Billing Process

When an ambulance transport is provided and completed, a complex process ensues to collect upon the charges incurred by that patient for the service. In general, most payers only reimburse ambulance services if the patient is transported to an approved destination, such as an emergency department or a return to a nursing home from a hospital discharge. In the case of WAS, a charge of $360 is also created in some cases when the patient is assessed, and no transport is provided. Since most payers do not cover a non-transport, the $360 is then typically billed to the patient. This process for WAS is simplified and outlined below in Figure 1:

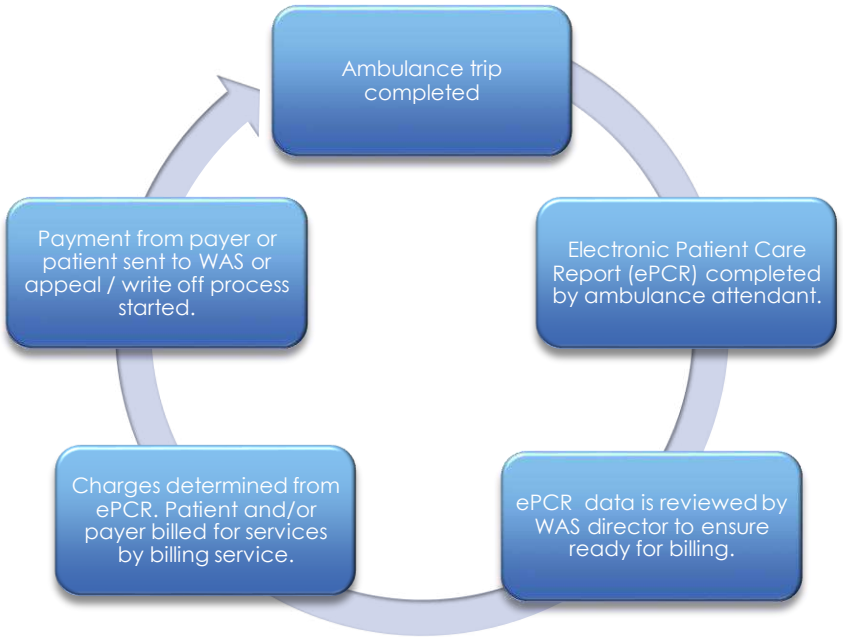

Figure 1 – General billing cycle for WAS.

Wabasha Crew and Manager Responsibility

Billing processes rely heavily on the information gathered from the crew members who are part of each respective ambulance response. If the ambulance crew fails to obtain the correct patient demographic information such as full name, address, date of birth, or insurance information, the claim will be delayed and potentially not paid. In addition to the information gathered, the ambulance crew must also document concise and accurate information relating to the patient's medical condition and subsequent treatment. This information along with the demographic, clinical findings, clinical treatment, and patient signatures all become part of what is called a "Patent Care Report" or PCR. In the case of WAS, an electronic PCR or "ePCR" is utilized in which crew members' documentation is computerized.

After evaluation, the primary areas of importance and the results of this review for the WAS staff area of responsibility are shown in Table 1:

Wabasha Ambulance Areas of Responsibility			
Key Performance Indicator (Financially Related)	**Goal >/=**	**WAS Estimate**	**Status**
Licensed ambulance crew all responses	100%	100%	Compliant
Ambulances licensed with State of MN	100%	100%	Compliant
Loaded mileage properly documented	95%	95%	Compliant
Patient demographic documentation	90%	95%	Compliant
Patient face sheet obtained while at hospital (crew)	90%	95%	Compliant
Patient signature obtained/ or reason no signature documented	100%	100%	Compliant
PCS Obtained for Hospital Transfers	90%	100%	Compliant
Timely submission of completed charts to billing service (< 7 days)	90%	100%	Compliant
Timely charting of ePCR by crews: < 4 hours	90%	90%	Compliant
Third party (non billing company) collection agency agreement	100%	0%	Non-compliant
Claims submitted to MN Revenue Recapture when appropriate	90%	0%	Non-compliant

Table 1 - Key Performance Indicators for Wabasha responsibility.

Third Party Billing Service Responsibility

WAS utilizes a third-party company to process all billing claims generated by WAS. In 2021, WAS changed billing company vendor to ECP Services, LLC. After an ambulance run is completed, the EMT must chart the medical assessment and treatment rendered, along with general patient demographic information using the Image Trend Field Bridge software. Once documented by the crew members, the ambulance manager reviews the ePCR charts to ensure they are complete, and the information is ready for the billing process. The ePCR data then flows to the State of Minnesota data collection website, MNSTAR. The billing agency can access MNSTAR and export the trips and charts into their software to begin the billing process. Data submission to the State of Minnesota is required by all MN ambulance services. In addition to the export of ambulance responses to the current billing company, a log of individual accounts and receivables is kept by the Wabasha deputy clerk. The general services provided by ECP are listed below:

- ECP will import data from all billable ambulance trips received from WAS into ECP's Billing software to facilitate the accurate submission of claims to all insurance carriers in electronic or paper format.

- ECP will follow established billing industry guidelines for ambulance services and make reasonable efforts to ensure the services provided by WAS are billed accurately and timely. ECP will bill services rendered by WAS within 5 business days after the incident is sent to ECP for billing.

- Once all insurance coverage is exhausted, ECP will invoice the patient or responsible party who incurred the ambulance charges, followed by a second invoice 30 days later, and 30 days later, a final notice to advise the recipient to remit payment to avoid further collection efforts.

- All monies and remittance advice for electronic payments received by ECP on behalf of WAS will be posted to the corresponding accounts weekly, at a minimum, and deposited to account via Remote Deposit Capture.

- All mail and correspondence will be processed by ECP in a timely fashion, where ECP will respond, or otherwise act on the corresponding account, and leave a record in the account of the correspondence.

- ECP will maintain a toll-free number for customer service inquiries and have available staff from Monday through Friday from 8:00am to 4:00pm Central Standard Time. Any voicemails will be returned within 1 business day.

- ECP will submit a monthly reporting package to WAS that includes, at a minimum, the Charges, Adjustments, Payments, and Discounts entered during the previous month, as well as an Accounts Receivable aging report.

- ECP shall make all payment records available to authorized representatives of WAS for review and auditing within a reasonable period of a request by WAS.

Most of the responsibility of the billing company is to parse the information provided by WAS into a billable format in which it can decide as to the level of service, the number of loaded miles, and any procedures or supplies which should be billed. The billing company relies heavily on the WAS ePCR and crew members to obtain insurance or payer information required to process the claim. Typically, when a patient is transported to an area hospital, the hospital provides the crew with a registration form containing demographic and insurance information. If this information is not available immediately after the transfer, the receiving hospital is typically obligated to provide the information to WAS upon request.

The KPI metrics below identify a few general but essential elements in which the billing company is responsible. While the billing company does not track all these elements directly, in discussion with their staff we were able to determine their score with fair accuracy. Table 2 below shows the general score related to the billing company.

ECP Billing Areas of Responsibility			
Key Performance Indicator (Financially Related)	**Goal**	**ECP Estimate**	**Status**
First invoice sent within 7 days of receipt of billable run report	90%	100%	Compliant
Compliance with billing schedule outlined in contract	90%	100%	Compliant
Customer service complaints - annual	< 2	100	Compliant
Written billing processes shared in contract	Yes	100%	Compliant
Credit, debit cards, electronic payments accepted from patients	Yes	Yes	Compliant
Patient automated payment plans accepted	Yes	Yes	Compliant
Training (at least annual) provided to ambulance staff	Yes	Yes	Compliant
Monthly and Ad Hoc reports provided to ambulance leadership	Yes	Yes	Compliant
Collaborates with ambulance service on setting rates	Yes	Yes	Compliant

Table 2 - Key Performance Indicators for the billing company area.

Closing Process – Month End

With general ambulance billing practices, the month-end close is an especially vital component in the overall management of the revenue cycle. The month-end closing practices must be consistent from month-to-month, so accounts are not overlooked or neglected, and reports are accurate with the ability to be trended. Some general concepts related to closing include:

- Creation of an actionable timeline which can be consistently adhered to by both WAS and the billing company. The billing company should be responsible for taking the lead on this process.
- The importance of prompt and accurate documentation of ambulance runs must be understood and supported by the ambulance manager and disseminated to all crew members.
- Accounts unable to be billed prior to closing should be accounted for through journal entries each month and reconciled when billed.
- Month-end data should be tracked to allow year-to-date trending and year-end totals.
- At a minimum, payer mixes, write-offs, refunds, trip counts, contractual allowances, and AR aging variables should be tracked monthly.

Billing Process Summary

After speaking with both WAS and the billing company staff regarding the billing process, all involved are performing well and meeting most billing process best practices and measures. The KPIs listed above are not routinely tracked by either WAS or the billing company but were determined based upon brief assessments and interviews with the staff of both entities. There is potential for inaccuracy in the KPIs, but this consultant feels it is important to outline some of the core pieces which should be tracked as part of the billing process.

With the change in billing company vendors occurring in October of 2021, a review of the previous billing vendor's processes and practices is not relevant. However, the change to the current vendor improved the overall billing practices and KPI scores as compared to the information reviewed related to the previous vendor.

Recommendations:

- There are many older patient accounts moved from the previous billing service to the current vendor. Many of these accounts have significant outstanding balances and extra attention should be given to collecting on them. Unfortunately, it is likely that many of these older accounts have gone beyond the timely filing requirement of one year for Medicare.
- WAS does not currently have an agreement with a collection agency. Utilizing a collection agency in addition to the billing agency will provide additional methods in which self-pay accounts will be reimbursed. This is a high priority recommendation as there is more than $50,000 of self-pay accounts older than 6 months. It is common for a collection agency to recover 15-30% of write-offs.
- Minnesota Revenue Recapture is not utilized by WAS and could be. The process is free, simple to use, and should be done routinely. It is common to recover between 5% and 10% of self-pay accounts previously deemed uncollectable.
- Ensure that the ePCR documentation is completed in full by the ambulance crew on the call. Any additions or addendums related to patient care must be documented by and signed by the attending crew.
- The internal WAS billing account spreadsheet should be kept updated regularly and reconciled monthly with the billing company. The worksheet should separate

out the base rate and the mileage charges. This worksheet is the core account record that the city has and must be kept current.
- Monitor ePCR completion with a goal of having at least 90% of the written reports completed within one hour of the call (back at the station) and 100% within two hours.
- Establish a monthly or quarterly meeting with the billing company in which the ambulance director, city administrator, and city financial director, review the previous month's revenue and collections activity.

Payers and Payer Mix

Most of the individuals in the United States use a "third-party" healthcare payer, such as commercial insurance, Medicare, or Medicaid. These payers are billed for services rendered by an ambulance service or other healthcare provider on behalf of, and for the benefit of, the patient. The covered patient is known as a beneficiary of the payer benefit.

In ambulance billing, it is a best practice to categorize the various payers into common categories. For the purposes of this analysis the categories will be classified as follows:

- **Medicare:** Federally funded and the general healthcare benefit for people ages sixty-five and older in the U.S (United States). Medicare recipients will often utilize a third-party administrator where the patient benefits will vary slightly. Ambulance services must "accept assignment" from Medicare, meaning they must accept what Medicare deems allowable, inclusive of a patient co-pay and/or deductible, for ambulance charges as payment in full. Medicare Advantage plans, which are plans where Medicare contracts with commercial insurance companies to provided Medicare-type benefits, are also included in this payer, and typically reimbursed at Medicare rates.
- **Medicaid:** Administered by the State of Minnesota using a combination of federal and state dollars, Medicaid is intended for individuals with lower income and/or disability and the financial inability to obtain other forms of health insurance or health coverage. Ambulance services must also accept assignment from Medicaid. Medicaid, for purposes of this report, also includes MinnesotaCare which is a State provided payer.
- **Government:** In addition to Medicare and Medicaid, there are other governmental payers. These other payers include Tri-Care, a healthcare benefit for military personnel, the Veterans Administration which provides healthcare benefits for military veterans, and other less common state or federal payers.
- **Commercial/Private Health Insurance**: Typically, most employers offer group health insurance to their employees. Commercial health insurance plans and their benefits vary greatly. Automobile or other Liability Insurance are also included here.
- **Private Pay (patient):** The patient responsibility due to not having any other payer (no insurance) or the part of an ambulance bill that the insurance company or Medicare deems the patient responsible**.** This includes co-pays and deductible portions not covered by other payers.

Regardless of the ambulance billed amount, each payer type reimburses or "pays" the ambulance service at a different rate and using a different process. When a payer is invoiced for charges related to the type of service rendered, the portion of that charge expected to be collected varies from payer-to-payer, as discussed above. The portion of the invoice not collected will fall into one of the three categories below.

- **Contracted Allowance**: For ambulance services to be reimbursed for services by Medicare or Medicaid on behalf of its beneficiaries (patients), the ambulance service must agree to accept assignment, meaning the amount reimbursed by the payer including beneficiary co-pays and deductibles is "payment in full." The remaining amount is legally uncollectable and is considered the contractual allowance. If an ambulance service signs a contract with an insurance company for a reduced rate, these "discounts" would also be considered contractual allowances.
- **Write-Off:** When an ambulance bill or a portion of the bill becomes the responsibility of the patient, such as in the case of a co-pay, a deductible, or the patient not having any coverage, and the patient fails to pay the required balance due, it is considered a write-off. These claims are typically turned over to a collection agency and should be submitted to the MN Revenue Recapture program in which a smaller portion may still be recovered.
- **Charity Care:** Typically, in healthcare, it is a recommended practice to have a debt forgiveness policy in which low-income patients with true inability to pay have options. A Charity Care policy must be administered consistently, and proof of income must be provided.

Tables 3 & 4 below demonstrate recent WAS ambulance charges and how the various payers can impact that charge.

WAS Average FFS Medicare Transport Breakdown October 2021 – June 2022)	
Average charge for an ambulance "trip" (base rate + mileage)	($1,612.86)
Medicare paid/allowable amount (includes deductible and co-pay)	$461.97
Remaining balance/not allowed to attempt to collect	($1,085.92)

Table 3 – 2021-2022 Average Medicare per-transport collections.

WAS Average Insurance Transport Breakdown October 2021 – June 2022)	
Total charges for an ambulance "trip"	($1,618.89)
Avg Insurance payment (includes patient portion)	$968.90
Open Balance/Not likely to collect	($482.74)
Total Written Off or Given Back to Insurance Company (BCBS)	($155.71)

Table 4 – 2021-2022 Average commercial insurance per-transport collections.

It is essential that an ambulance service understands its mix of various payers as all payers do not reimburse equally. Figure 2 below, when controlled for a single U.S. dollar, shows how reimbursement/payment to WAS for the same service can vary from payer to payer.

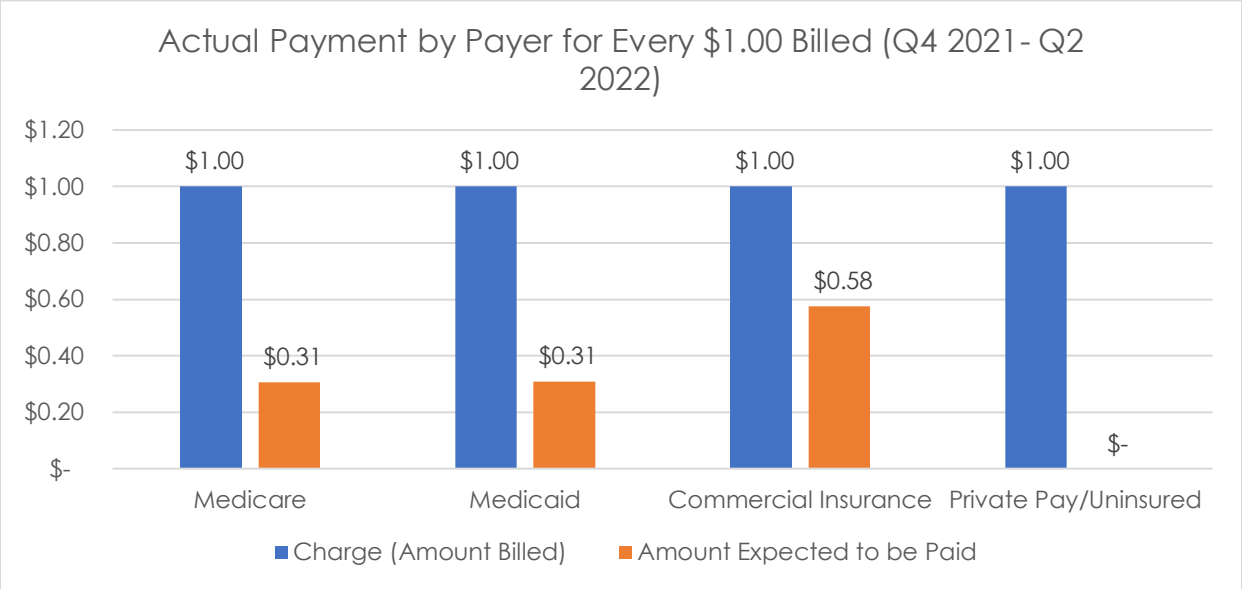

Figure 2 – Chart shows expected payment received by payer class up to the payer threshold.

Figures 3 & 4 illustrate the payer mix for WAS in terms of the total billed charges and the total amounts collected. 61.8% of total transports in the latter part of 2021 and first half of 2022 were for Medicare patients (Figure 3). This 61.8% of transports made up only 53.5% of actual revenue received, for purposes of these figures, Medicare, as mentioned earlier, also includes Tri-Care which is a military healthcare benefit through the federal Government, and any Medicare Advantage plans. Medicaid, for this report, includes MinnesotaCare which is reimbursed similarly to Medicaid. It is also noteworthy to mention that as of early November 2022, there have yet to be any self-pay payments received.

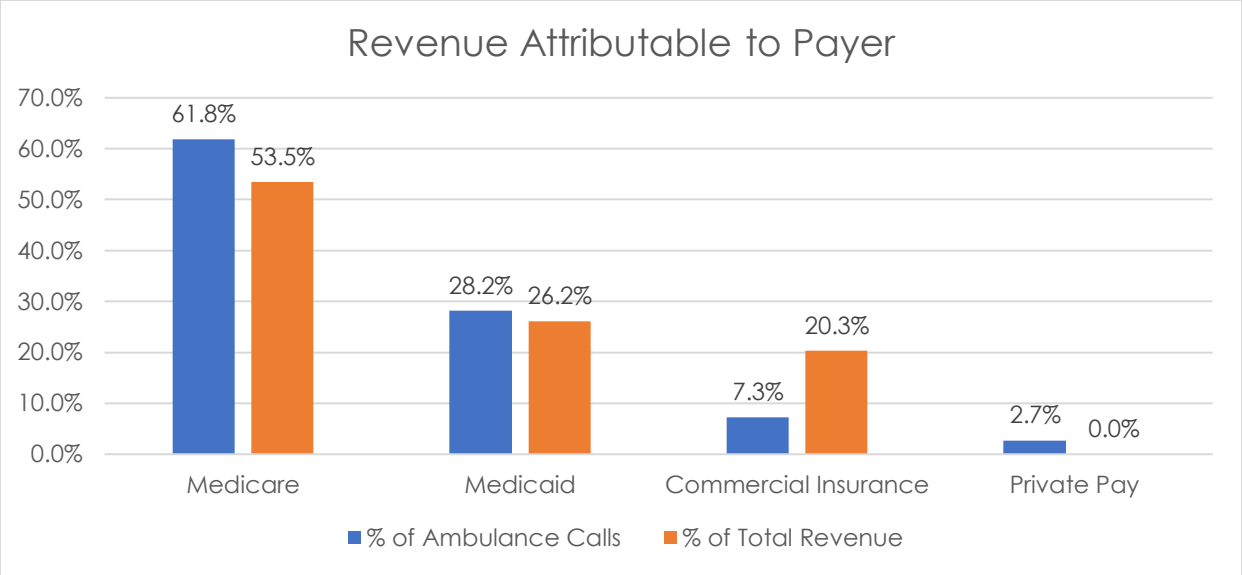

Figure 3 – Shows the percentage of WAS ambulance transports and revenue attributed to each payer.

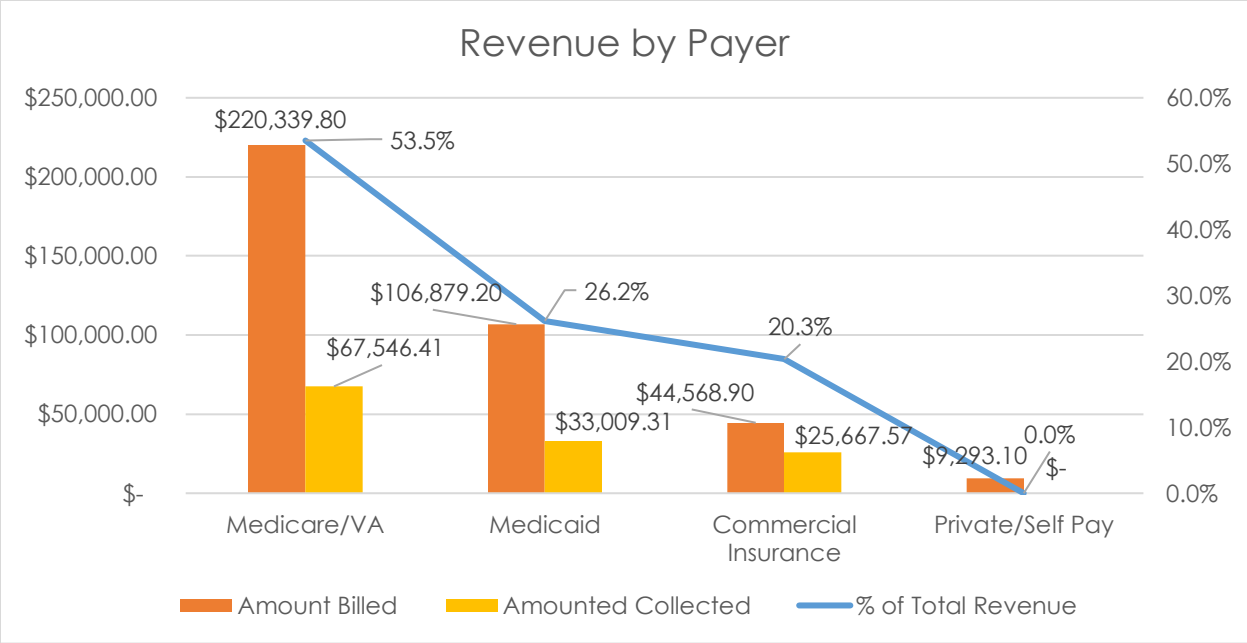

Figure 4 – Total revenue for each payer in 2019 and payer percent of total revenue for the entire year.

Payer Mix Summary

The Wabasha Ambulance service area has a high (80-90%) combined percentage of Medicare, Medicaid, and other governmental payer patients according to the information provided to this consultant. As a result of this high governmental payer mix, increasing ambulance rates and charges will have no impact on 80-90% of ambulance billable transports. In addition, with 3% of ambulance charges attributed to the responsibility of individuals, it is imperative that the billing company and WAS work closely to collect these outstanding balances. Like other healthcare national trends, billable run

volume was stagnant in 2021 and YTD 2022. After a slow start in 2021, due to the transition from the previous billing company, 2022 accounts are on track for routine billing. Account aging is within typical ranges for governmental and commercial payers but concerning in the private pay categories due to lack of account write-offs.

Payer Recommendations:

- The billing company currently includes a payer mix trends in its monthly reports to WAS. This report should be aggregated toward annual trends as monthly run volumes are small resulting in larger fluctuations.
- Consider creating a Charity Care policy in which low-income individuals could be given different payment options and considerations for debt forgiveness.
- Additional efforts should be made to recover accounts that are patient responsibility. While these accounts are typically harder to collect, WAS collection rates from this study's time have no revenue. This component ties closely with the lack of a collection agency and lack of utilizing MN Revenue Recapture.
- Twelve ambulance transports in the most recent one-year period were for patients with primary insurance coverage of Blue Cross/Blue Shield (BCBS) commercial coverage. WAS does not have an agreement with BCBS to discount their rates but has reduced some accounts. Some commercial payers will inform ambulances services that they must accept their full payment at a less than billed rate. WAS should work directly with patients to ensure claims are paid in full.

WAS Service Rates Analysis

Billing / Service Rates Overview

Ambulance services charge patients based upon the level of service and the distance in which the patient was transported to a hospital or other covered destination. The charges which make up most of the revenue are the "base rate" and the "mileage rate." The base rate is reimbursed by Medicare, Medicaid, and most insurance companies at different dollar amounts dependent upon the level of care provided. The transporting mileages are reimbursed at a set per mile rate billed in 1/10th mile increments. The mileage reimbursement is a standardized rate for Medicare and Medicaid and is independent of the service level provided. WAS is in what is deemed by Medicare as a "Rural" locality and is reimbursed at a higher rate than designated urban localities. Table 5 shows the current rate structure for WAS which was implemented in 2019.

2018-2022 WAS Billing Rates		
Service Level	**Resident**	
Mileage (per mile)	$	21.00
BLS non-emergency	$	900.00
BLS emergency	$	1,440.00
ALS non-emergency	$	1,080.00
ALS Emergency	$	1,710.00
ALS2 emergency	$	2,475.00
Specialized Critical Transport (SCT)	$	2,925.00
Treat no transport	$	360.00
Service Fee	$	100.00

Table 5 – WAS service rates set in 2019 and current through 2022.

The process of setting ambulance rates can be complicated as numerous considerations must be factored into the analysis. Contractual allowances, the cost of providing the service, the area blend of payer types, revenue from outside sources such as special assessments or per capita fees, fundraisers, and most important, is the funding of the financial component of staff recruitment and retention.

When setting the rates, it must be clearly understood what the expected return on the added charges will produce. Keep in mind that WAS rates are already set above the governmental payer allowances such as Medicare and Medicaid, and therefore will be no additional return on these increases. Charging for supplies and procedures is not reimbursable by Medicare, Minnesota Medicaid, or many commercial insurance companies. Including such ancillary charges should be based on reimbursement data analyzed by the billing agency and a mutual decision between WAS and the billing company. Table 6 shows a comparison of the 2022 WAS rates to the Medicare and Medicaid allowable reimbursement. WAS has not set rates for SCT (Specialty Care Transport) as they believe this service will not be part of their responses.

2022 Reimbursement Schedule and WAS Rates	HCPCS	Medicare	MN Medicaid	WAS 2022 Rates
Medicare/Medicaid Reimbursement	**HCPCS**	**Medicare**	**MN Medicaid**	**WAS 2022 Rates**
BLS and ALS Mileage	A0425	$8.10	$ 7.79	$ 21.00
ALS Non-Emergency	A0426	$304.69	$ 293.03	$ 1,080.00
ALS1 Emergency	A0427	$482.43	$ 430.03	$ 1,710.00
BLS Non-Emergency	A0428	$253.91	$ 244.17	$ 900.00
BLS Emergency	A0429	$406.25	$ 430.03	$ 1,440.00
ALS 2	A0433	$698.25	$ 671.68	$ 2,475.00
SCT	A0434	$825.20	$ 793.80	No Set Rate

Table 6 – 2022 Medicare and Medicaid reimbursement by service provided and current Wabasha charges.

Figure 5 below shows a theoretical look at potential rate increase for WAS utilizing the year 2022 as base. While total charges increase significantly, the actual resulting revenue is minimal and will be shared between commercial insurers and individuals without insurance coverage.

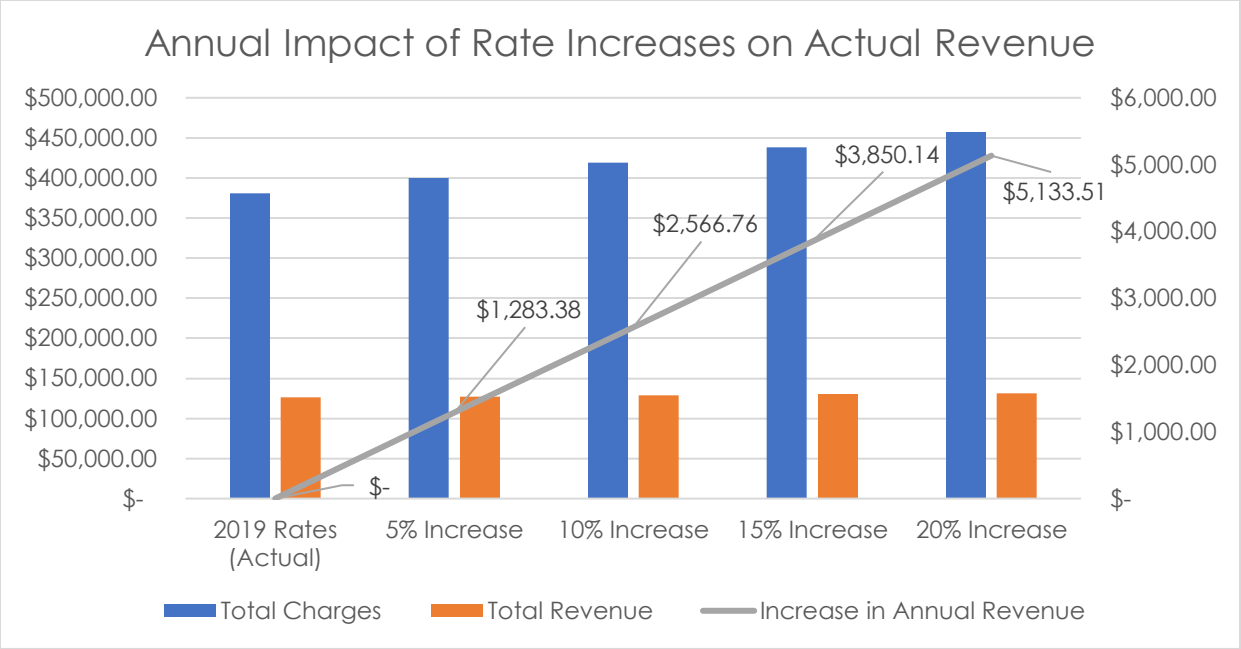

Figure 5 – Shows the expected impact of various rate increases.

Service Rate Analysis Summary

It is important to understand that Medicare, through The Centers for Medicare and Medicaid Services (CMS), has performed studies on the costs to operate ambulances and have determined their reimbursement fees based upon these studies. Even after Medicare reimbursement rates are set, ambulance services must determine their individual costs associated with their operations and set their own rates accordingly. Commencing in the year 2020, CMS is mandating that ambulance services that provide Medicare covered services submit revenue, cost data, and utilization data to CMS (U.S. Centers for Medicare & Medicaid Services, 2020). While this four-year data collection initiative has been interrupted because of the pandemic, WAS selected as a Year 1 organization. This means that with the delay, WAS will need to collect data starting in 2022 and report data in 2023.

Ambulance rates for ambulance services were increased effective in 2019. It is understood by this consultant that rates for similar services were analyzed, and the decision made to make the increase. If WAS decides to increase the current rates significantly, it must be prepared to appeal for an increase in commercial payer denials deemed as above customary charges. In addition, patients with high deductibles or lack of insurance coverage will be receiving significant out-of-pocket ambulance bills. This consultant believes the current (2019) WAS rates are mostly within the range of similarly situated ambulance services with similar revenues and expenditures.

Other Areas of Potential Revenue

Ambulance services in the State of Minnesota are fortunate to have strong State-level legislative advocates such as the Minnesota Ambulance Association who have worked hard to help ensure the sustainability of rural services such as Wabasha. Two specific programs applicable to WAS and should continue to be fully leveraged include Revenue

Recapture, as discussed earlier in this document, and Supplemental Medical Assistance payments.

Revenue Recapture

Ambulance services and municipalities in Minnesota can use Revenue Recapture to attempt collections on individuals who owe money and are in collections status. Essentially, entering an account into Revenue Recapture places a lien on an individual's tax refund and the Minnesota Department of Revenue (DOR) will withhold up to the outstanding balance amount and issue the funds directly to the ambulance service. Specific attempts and notifications to collect must be made prior to using Revenue Recapture and the ambulance service must enter the accounts into the MN DOR system, and not the billing agency. WAS currently does not utilize this program as discussed earlier in this document.

Supplemental Medical Assistance Payments

This program was recently expanded by the Minnesota Legislature to include additional municipal ambulance services. This program supplements Medical Assistance ambulance runs by reimbursing the ambulance service 50% of the difference between the average Medical Assistant payment and the average commercial insurance payment for each Medical Assistance ambulance trip. The program is voluntary and has stipulations of which WAS does qualify (below):

- Is enrolled as a Medical Assistance fee-for-service provider (providers who only participate in Medical Assistance via managed care plans are not eligible);
- Is owned and operated by a governmental entity;
- Is not owned or operated by a Tribal government;
- Provides the required data and funding, and;
- Has chosen to participate in the Supplemental Payment Program;

To participate in the Ambulance Supplemental Payment requires that WAS/Wabasha contribute a tax to the program which in turn will increase the federal portion of reimbursement beyond that tax. The exact return on this contribution is determined by submitting the data to the Minnesota Department of Revenue.

Revenue Cycle Recommendations:

- Immediately prepare for and begin reporting data to CMS as part of the required data collection initiative. WAS must collect data for CY 2022 and report in CY 2023. Please reference www.ambulancereports.org and the Medicare website for more information.
- WAS should continue to participate in the Supplemental Medical Assistance payments program through the MN DOR. It does not appear as though WAS has submitted to this program and doing so could return several thousand dollars annually.
- WAS should meet with their billing agency regularly with a special annual meeting, typically in the fourth quarter, to establish billing rates for the following year.
- When developing a relationship and contract between a collection agency and Wabasha, it should consider including, at a minimum:

    - Letter writing service. This is a letter that goes out from the collection agency to the delinquent account owner stating that the account is now in collections and gives the party 30 days to pay or decide before the account goes to credit reporting. This service is commonplace and can be included for a small fee.
    - A Business Associate Agreement (BAA) should be signed by both entities stating that they will be sharing information for billing practices.
    - A flat fee or commission both entities can agree upon.
- Ensure that WAS and the billing company mutually develop a policy which determines when delinquent accounts are transferred to a collection agency (once established).
- Ambulance director should be trained in billing and reimbursement principles.
- Ensure all billable runs are complete and properly documented and then sent to the billing company by the end of the month.
- Utilize Minnesota Revenue Recapture to its full capacity and ensure staff are obtaining patient social security numbers (SSN). When missing an SSN, the ambulance manager should work with the receiving hospitals to gather this information.
- The billing services agreement between WAS and the billing company seems cost effective.

FINANCIAL ASPECT OF OPERATIONS

Overview

The revenue component of operating an ambulance service, as can be determined from reading the preceding pages of this document, is complex. In similar fashion, the expense portion, especially when it comes to ambulance labor costs, can be complicated and confusing. Even with considerable experience in the ambulance industry, this consultant must spend substantial time identifying and isolating the various revenue and expense factors which influence an ambulance operational financial review.

Table 7 below shows the audited financial position of the City of Wabasha for 2021. The ambulance service operations are included in the Governmental Activities section.

City of Wabasha's Summary of Net Position

	Governmental Activities			Business-type Activities		
	2021	2020	Increase (Decrease)	2021	2020	Increase (Decrease)
Assets						
Current and other assets	$ 3,743,570	$ 3,495,618	$ 247,952	$ 993,306	$ 745,829	$ 247,477
Capital assets	10,886,676	11,427,313	(540,637)	7,908,749	8,045,491	(136,742)
Total Assets	14,630,246	14,922,931	(292,685)	8,902,055	8,791,320	110,735
Deferred Inflows of Resources						
Pension resources	1,031,363	479,611	551,752	67,181	24,847	42,334
Liabilities						
Noncurrent liabilities outstanding	2,792,138	3,646,178	(854,040)	941,720	1,311,042	(369,322)
Other liabilities	226,532	80,937	145,595	25,455	35,742	(10,287)
Total Liabilities	3,018,670	3,727,115	(708,445)	967,175	1,346,784	(379,609)
Deferred Outflows of Resources						
Pension resources	1,330,311	477,335	852,976	83,356	6,013	77,343
Net Assets						
Net investment in capital assets	9,119,676	9,207,313	(87,637)	7,073,041	6,876,491	196,550
Restricted	1,078,657	1,120,629	(41,972)	-	-	-
Unrestricted	1,114,295	870,150	244,145	845,664	586,879	258,785
Total Net Position	$ 11,312,628	$ 11,198,092	$ 114,536	$ 7,918,705	$ 7,463,370	$ 455,335

At the end of the current fiscal year, the City is able to report positive balances in all three categories of net position, both for the City as a whole, as well as for its separate governmental and business-type activities.

Table 7 – YE 2021 excerpt from the City of Wabasha overall audited financials.

Financial Statements

The Income Statement (Table 8) was reformatted based upon information provided by the City of Wabasha. The years 2020 and 2021 include categorical revenue and expense obtained from the audited financials. The 2022 column is the actual revenue and expense for the current year through August. This statement of operations does not include depreciation of capital purchases such as ambulances, medical equipment, or

property ownership or leasing. The lack of these inclusion of such important expenses fails to show the genuine cost of operating the ambulance service.

Account Description	2020 Actual	2021 Actual	2022 Through Aug 31	2022 Anticipated	2023 Proposed
R 100-34207 Ambulance Services - Patient Revenue	$ 186,556.69	$ 178,879.19	$ 153,845.00	$ 230,767.50	$ 240,000.00
R 100-34212 Ambulance Training Center Revenue	$ -	$ 310.00	$ -	$ -	$ 500.00
Grants and awards					
Other					
Service Revenue	**$186,557**	**$179,189**	**$153,845**	**$230,768**	**$240,500**
Expenses	**2020 Actual**	**2021 Actual**	**2022 Through Aug 31**		**2023 Proposed**
E 100-420-42500-101 Full-time Employees-Regular	$ 143,692.94	$ 151,353.59	$ 97,579.71	$ 146,369.57	$ 169,495.22
E 100-420-42500-103 Part-time Employees	$ 69,681.49	$ 83,129.67	$ 54,019.63	$ 81,029.45	$ 83,000.00
E 100-420-42500-121 PERA Contributions	$ 10,996.59	$ 11,468.55	$ 6,812.76	$ 10,219.14	$ 12,562.14
E 100-420-42500-122 FICA Contributions	$ 12,786.14	$ 14,150.81	$ 9,177.21	$ 13,765.82	$ 15,530.70
E 100-420-42500-124 Medicare Contributions	$ 2,990.32	$ 3,309.52	$ 2,146.20	$ 3,219.30	$ 3,632.18
E 100-420-42500-131 Health Insurance	$ 40,398.64	$ 36,672.76	$ 18,915.52	$ 28,373.28	$ 24,213.91
E 100-420-42500-133 Dental Insurance	$ 672.08	$ 1,164.48	$ 481.92	$ 722.88	$ 481.92
E 100-420-42500-134 Life Insurance	$ 1,022.97	$ 805.32	$ 426.25	$ 639.38	$ 871.68
E 100-420-42500-140 UNEMPLOYEMENT TAXES	$ -	$ -	$ -	$ -	$ -
E 100-420-42500-151 Workers Comp Insurance Premium	$ 12,561.50	$ 15,102.05	$ 16,233.31	$ 24,349.97	$ 14,000.00
E 100-420-42500-200 Office Supplies	$ 344.24	$ 207.70	$ 8,246.08	$ 12,369.12	$ 500.00
E 100-420-42500-206 Training Center Expenditures	$ 1,324.63	$ 1,715.67	$ 2,573.00	$ 3,859.50	$ 2,000.00
E 100-420-42500-212 Motor Fuels	$ 2,603.64	$ 3,520.39	$ 3,067.79	$ 4,601.69	$ 3,000.00
E 100-420-42500-215 Oxygen-Supplies	$ 1,111.76	$ 966.63	$ 257.33	$ 386.00	$ 1,000.00
E 100-420-42500-217 Medical Supplies	$ 15,864.11	$ 12,721.99	$ 6,990.74	$ 10,486.11	$ 10,000.00
E 100-420-42500-219 General Supplies	$ 2,436.41	$ 327.87	$ 1,560.26	$ 2,340.39	$ 1,500.00
E 100-420-42500-221 Equipment Maintenance/Parts	$ 1,616.37	$ 431.36	$ 1,834.07	$ 2,751.11	$ 4,000.00
E 100-420-42500-223 Building Maint/Repair Supplies	$ 1,141.67	$ 1,078.92	$ 555.01	$ 832.52	$ 1,000.00
E 100-420-42500-308 Continuing Ed	$ 8,712.22	$ 1,119.17	$ 1,061.70	$ 1,592.55	$ 6,000.00
E 100-420-42500-310 First Respondors	$ -	$ -	$ -	$ -	$ 1,000.00
E 100-420-42500-311 Contractor Fees	$ 14,406.49	$ 15,344.93	$ 11,220.24	$ 16,830.36	$ 16,500.00
E 100-420-42500-312 Computer Support	$ -	$ 302.77	$ -	$ -	$ -
E 100-420-42500-321 Telephone	$ 2,494.49	$ 1,736.99	$ 469.98	$ 704.97	$ 2,500.00
E 100-420-42500-322 Postage	$ 10.31	$ -	$ -	$ -	$ 50.00
E 100-420-42500-331 Travel Expense	$ 460.04	$ 615.33	$ -	$ -	$ 1,000.00
E 100-420-42500-350 Printing and Binding	$ 93.20	$ 283.38	$ 15.50	$ 23.25	$ 500.00
E 100-420-42500-361 General Liability/Property Ins	$ 5,224.00	$ 3,936.00	$ 3,593.00	$ 5,389.50	$ 5,000.00
E 100-420-42500-365 AMB/FIRE DISABILITY ACCIDENT	$ 1,681.02	$ 1,959.67	$ 5,863.00	$ 8,794.50	$ 3,000.00
E 100-420-42500-381 Electric/Gas Utility	$ 1,533.04	$ 1,884.61	$ 2,183.62	$ 3,275.43	$ 2,500.00
E 100-420-42500-401 Building Contract Maintenance	$ 720.75	$ 600.77	$ -	$ -	$ 1,000.00
E 100-420-42500-409 Maintenance Agreements	$ 475.75	$ 652.97	$ 511.24	$ 766.86	$ 750.00
E 100-420-42500-414 Vehicle Maintenance	$ 7,996.33	$ 1,782.23	$ 409.11	$ 613.67	$ 3,500.00
E 100-420-42500-430 Miscellaneous	$ 7,178.63	$ 4,120.06	$ 1,517.28	$ 2,275.92	$ 2,000.00
E 100-420-42500-433 Dues and Subscriptions	$ 1,180.00	$ 2,352.46	$ 571.48	$ 857.22	$ 1,200.00
E 100-420-42500-436 Insurance Deductible for Claim	$ 1,708.59	$ 4,411.07	$ -	$ -	$ -
E 100-420-42500-437 Misc Licenses and Permits	$ 350.52	$ -	$ -	$ -	$ 500.00
E 100-420-42500-570 Office Equipment & Furnishings	$ 38.00	$ 572.28	$ 149.99	$ 224.99	$ 1,000.00
E 100-420-42500-581 Uniforms	$ 3,224.51	$ 3,069.46	$ 781.79	$ 1,172.69	$ 3,000.00
E 100-420-42500-582 Radio Equipment	$ 2,187.00	$ 6,956.00	$ -	$ -	$ 2,000.00
Total Operating Expense	$ 380,920.39	$ 389,827.43	$ 259,224.72	$ 388,837.08	$ 399,787.76
Profit/(Loss) from Operations	**$ (194,363.70)**	**$ (210,638.24)**	**$ (105,379.72)**	**$ (158,069.58)**	**$ (159,287.76)**
Estimated Subsidy to Cover Expenses	$ 194,363.70	$ 210,638.24	$ 105,379.72	$ 158,069.58	$ 159,287.76

Table 8 - Income statement and budget 2023 comparisons 2020-2023.

Revenue

The City of Wabasha ambulance service accounting utilizes only two revenue accounts on its income statement to attribute ambulance service revenue. The areas are:

- Patient services revenue – generated by billing for transporting and caring for patients. The non-transported patient fees collected are also reported here.
- Ambulance training center revenues generated when the ambulance service staff teach classes for a fee.

Additional items which should be accounted for to illustrate the full cost of operations and would include at least the following:

- City and township contributions – general funding provided by various political entities to offset the negative operating margin. These funds could be recognized as an expense for the city and as a revenue for the ambulance service if formed as a business accounting unit.
- Training reimbursement from State of MN – typically for EMT training - pass-through.
- Grants/other reimbursements – typically funds from the State and Federal grants. CARES (Cardiac Arrest Registry to Enhance Survival) and stimulus funding may go into this area.

When combined, these areas make up the operating and non-operating revenue for WAS. As shown in Figure 6, patient billing revenue (service revenue) accounts for 40-60% of revenue depending on the time period with the balance being contribution subsidy from the City of Wabasha.

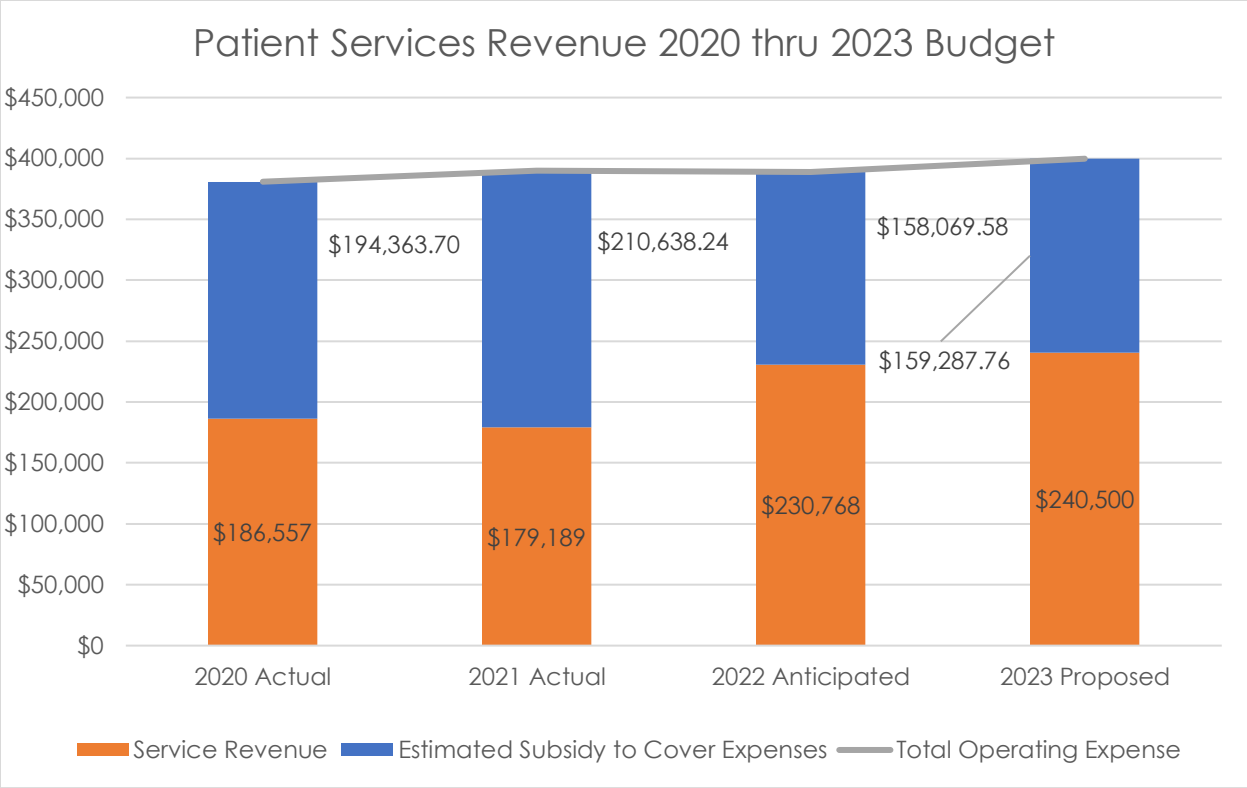

Figure 6 – Revenue by Source – budgeted vs. actual as reported from the city financials.

Figure 7 shows billable response volume for 2019, 2020, and year-to-date projected 2021. Volume appears to have decreased since 2019 and is on track for a 2021 decrease from 2020.

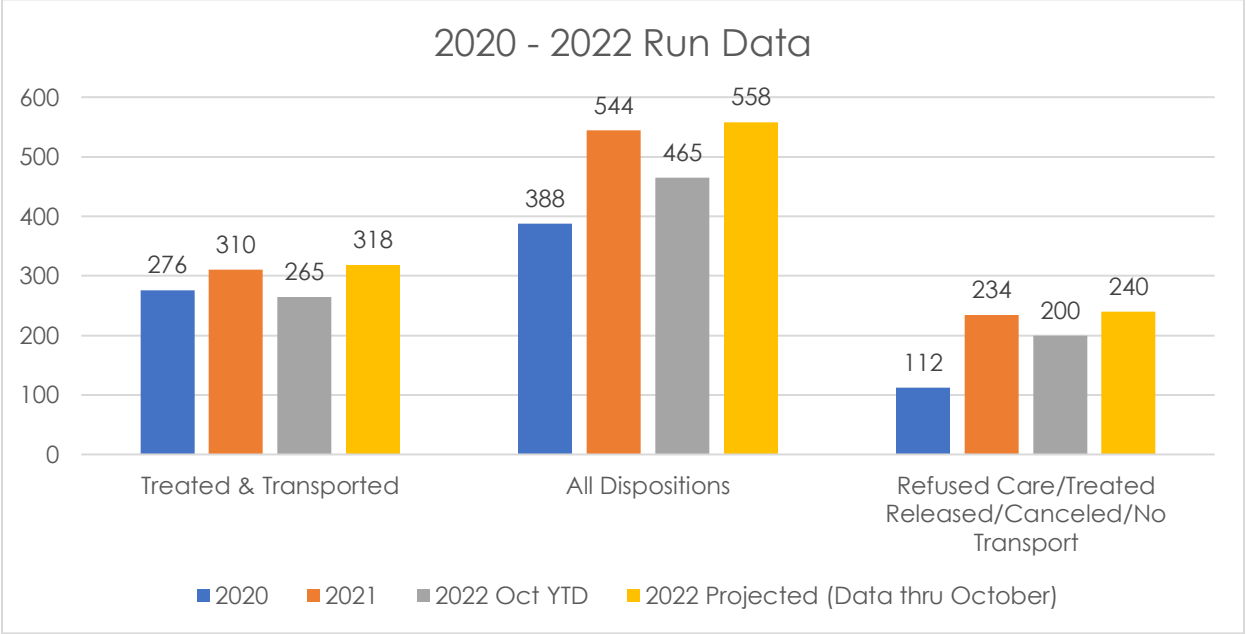

Figure 7 – Responses for 2020 through October 2022 and projected YE 2022.

Revenue Increase Recommendations - Operational

Most of the analysis of the revenue portion of WAS occurred in the revenue and billing sections of this document. There does not appear to be a potential to increase overall 911 patient revenue more than the overall operating expense.

Monitor No Load/No Transport Responses

Since not every 911 ambulance call is a life-or-death event, at times a patient may decide not to be transported to the hospital and often the person does not need transport. Such a response can be perfectly acceptable. However, WAS staff should continue to be aware of the potential liability associated with not transporting a patient in need of additional care by a physician or other health care provider in the emergency department.

The chart below (Figure 9) shows the three-year trend of no-transports to transports for 911 requests. WAS's non-transport rate is consistent across these years. WAS does have a set rate of $360 for patients who are provided with on-scene treatment but not transported to a hospital. As of this report, WAS has not charged a patient in 2021 or 2022 for this service. This area is less of a revenue generation opportunity than it is just general awareness.

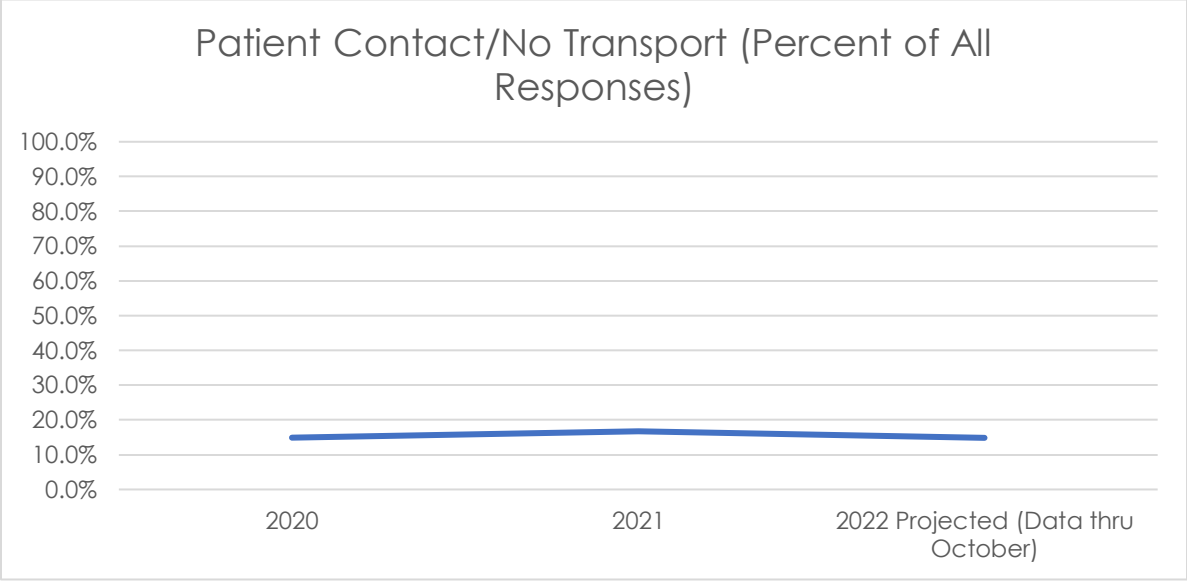

Figure 8 – Percent of total all responses as non-transports.

Hospital Transfers

Depending on the type of injury or illness a patient may experience when going to a local emergency department, there is a chance that the patient will need to be transferred to a larger hospital for more advanced care. Often, ambulance transport is required to safely move the patient to the larger hospital. Area hospitals such as those in Wabasha or Lake City often struggle to find an ambulance service with availability to transfer patients from their facility to another hospital or other health care facility. WAS, on occasion, has performed transfers for Gundersen St. Elizabeth's hospital in Wabasha at the Basic Life Support level.

There is market demand for inter-facility transport services in which WAS could consider participating. Figure 10 shows the percentage of transfers compared to overall responses, while figures 11 and 12 show overall historic average revenue and per trip transfer revenue. An initial report was provided to the Wabasha Ambulance Commission by this assessment team in January of 2023 which utilized limited actual data from performed transfers in 2021.

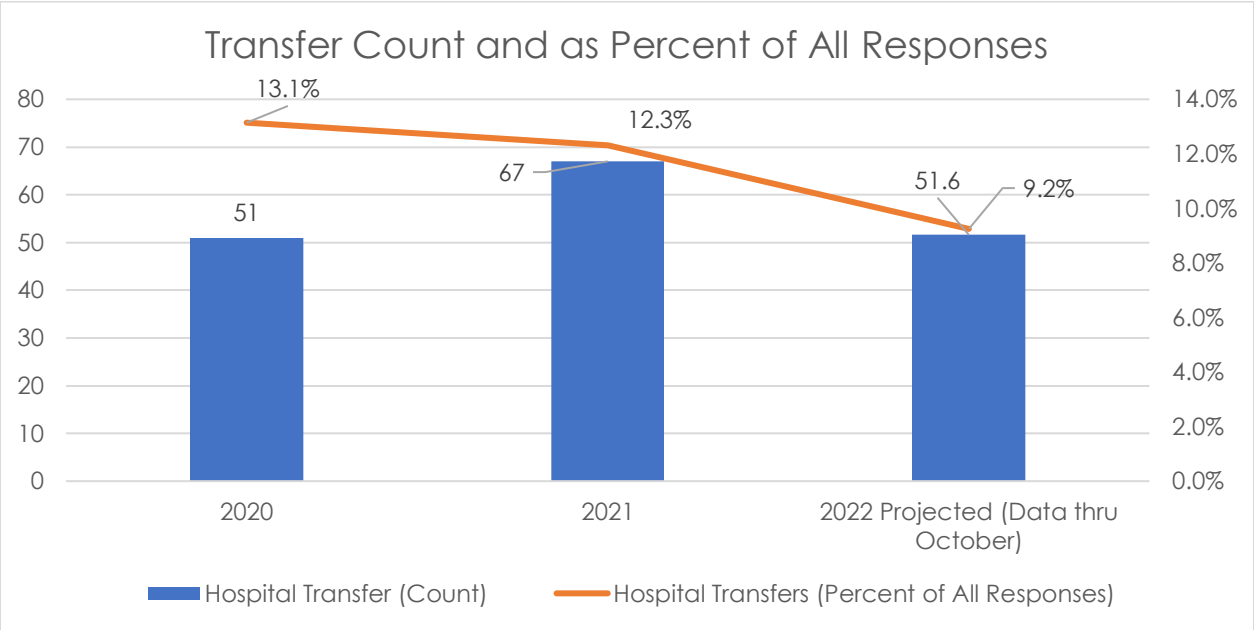

Figure 9 – Shows hospital origin transfer counts.

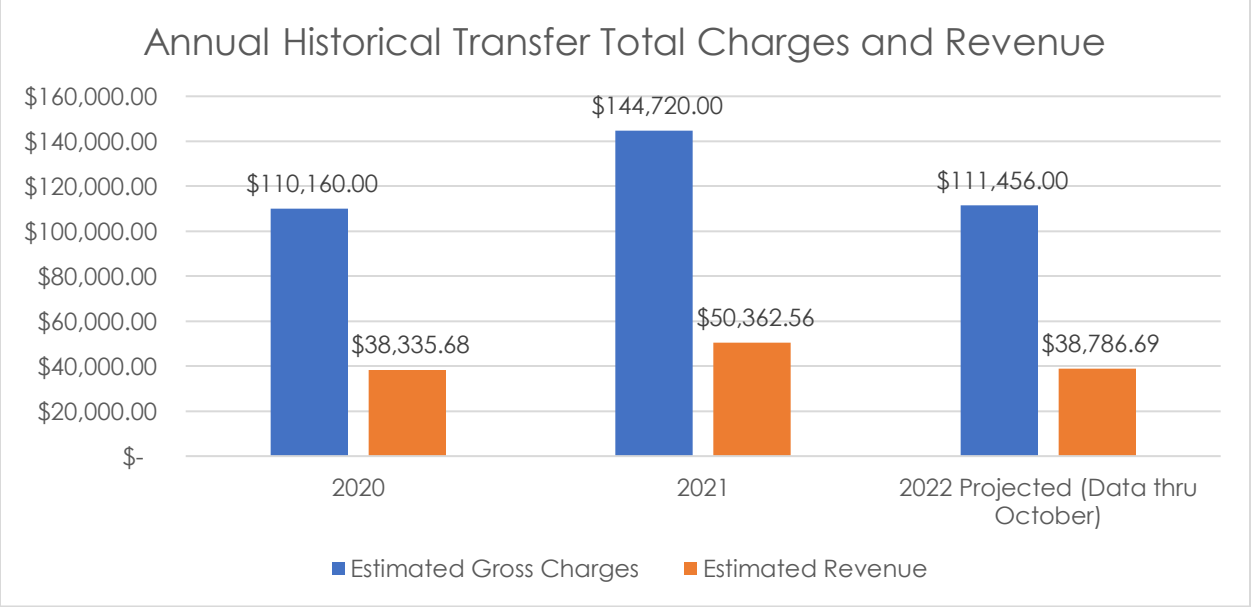

Figure 10 – Estimated charges and revenue (payments) attributed to transfers.

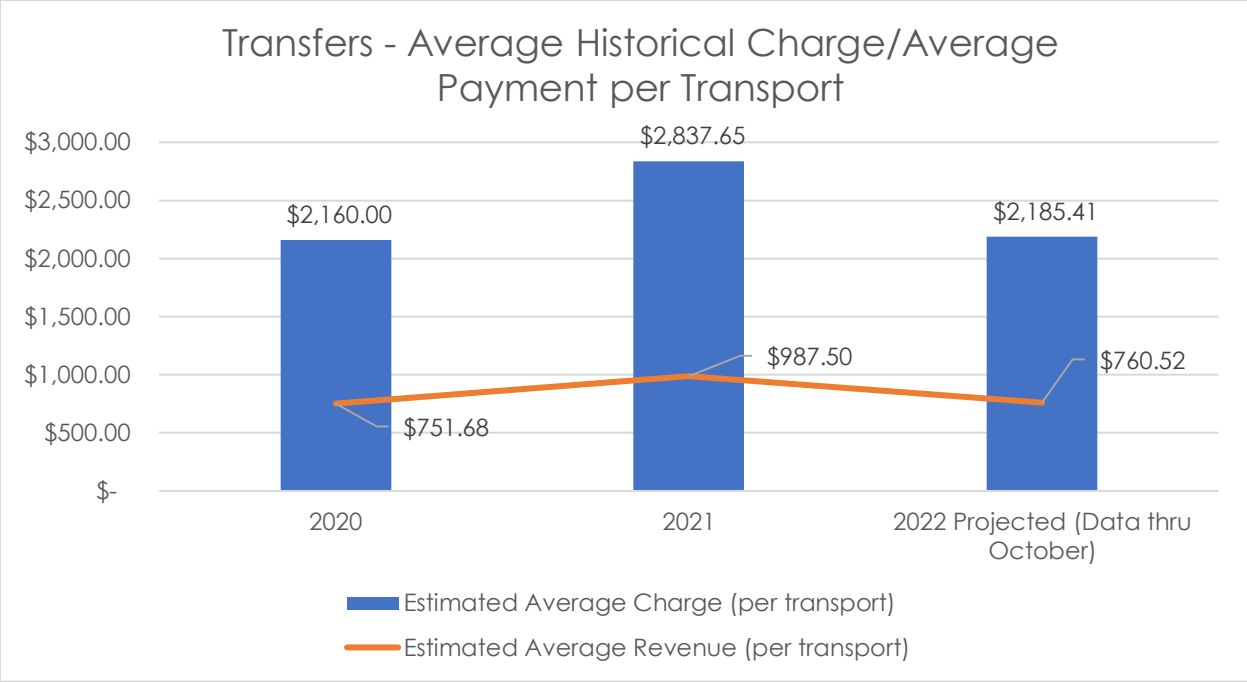

Figure 11 – Average per transfer charge and revenue (payments) received for each transport.

This assessment team was tasked with you evaluating the profitability of interfacility transfers for WAS and how additional transfers could provide an increased value to the community and the financial bottom line. To do this, an analysis was performed initially using limited data due to the low volume of transfers and later estimating typical payer reimbursement from Medicare. In addition, this assessment included a couple of slightly modified staffing arrangements which if implemented could increase the potential to perform more transfers.

When projecting future revenue and profitability, the following assumptions were used:

- Assumes full-time staff costs are included in the overall budgeted labor costs. Transfers performed during regular staff hours would only incur additional costs to backfill the station at on-call activation wages while the duty crew is away as shown in the "Duty Hours Staffing Model."
- The "After Hours Staffing Model" assumes the first crew is recalled from on-call and a second crew moved to activation pay to cover 911 while the transfer is occurring. In other words, the second crew would receive full pay to cover the response area while the first unit is out on a transfer.
- When a transfer is performed, that ambulance is typically out of town/service for 3 hours or 12.5% of the day.
- Labor costs include a 20% overall increase to cover payroll taxes and limited benefits.
- Data provided shows that 65% of 911 responses occur between the hours of 07:00 and 19:00 daily, hence the likelihood for a second unit response while the first unit is on a transfer is not simply divisible by 24 hours and must be weighted. For this analysis, we use a 20% likelihood that an additional response will occur during the

3-hour transfer between 07:00 and 19:00 and an 11% likelihood between 19:00 and 07:00.

- Since the Paid-On-Call model costs may be attributed to the staff on the transfer, the difference in cost must be calculated for the staff backfilling the second call.
- 440 average annual primarily 911 responses or 1.2 per day on average is used to calculate needed backfill while the first unit is on a transfer.
- The staffing configuration in this analysis uses one EMR and EMT as the crew and assumes a BLS Non-Emergency transport and associated charge.
- General supplies, cost of billing the trip, and other per-transfer incidentals included.
- Vehicle and fuel costs must also be calculated and directly attributed to each transfer. For this analysis, we used a diesel price of $3.50 per gallon and fuel efficiency of eight miles per gallon.
- Ambulance attributed usage is a formula which includes the purchase price of the ambulance divided by expected life span in miles (180,000) or 10 years, whichever comes first. In the case of WAS, 0.06% of the ambulance lifespan is reduced per average transfer, proportionally.
- We assume WAS will typically house and support two ambulances for both 911 and interfacility coverage. In other words, two ambulances are the minimum requirement for WAS which means we do not attribute dedicated ambulance to transfers.
- We do not include the cost of equipment in this transfer cost analysis. Equipment such as heart monitors, power cots, and power load systems will be replaceable on years of service and not usage in the case of WAS. In other words, this equipment will not wear out before its end of life based upon WAS low run volume.
- It is also assumed in this analysis that WAS will routinely operate two ambulances which will serve both interfacility and 911. Most of the financial overhead attributed to both units are present regardless of transfers.

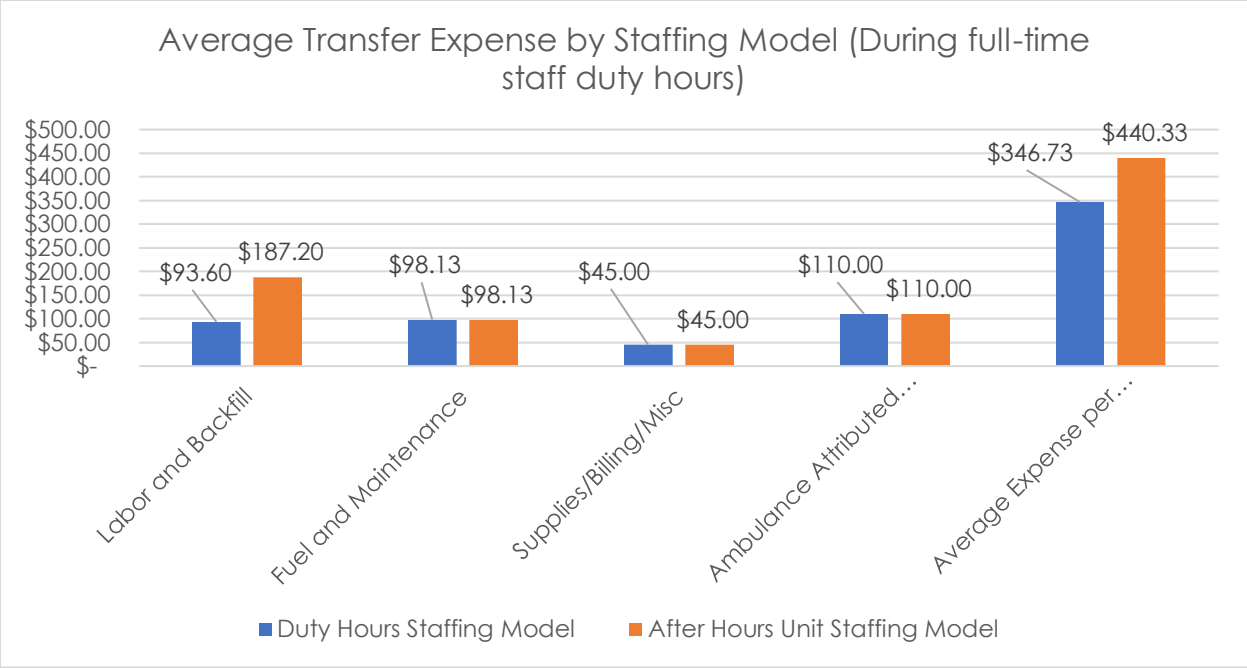

Figure 12 – Chart shows typical expenses attributed to the average 3-hour and fifty-five loaded miles WAS transfer.

It should be noted that Medicare, Medicaid, and most commercial payers scrutinize transfers and are specific about when they will consider the transfer a covered service and reimburse for the trip. It does not appear WAS has any issues with non-billable transfers, however many of these trips were billed at the BLS Emergency rate which is a higher reimbursement than the typical expected BLS Non-Emergency.

The staffing model scenarios used to examine transfer performance capability and profitability are summarized here:

- Primary crew transfer: During 07:00 to 19:00 when full-time staff are on duty, transfers will be performed by this primary crew. When primary is on a transfer, the second crew will be placed on duty at their regular activation wage for EMR and/or EMT. The charts below assume an EMT/EMR crew for the on-call backup crew.
- After Hours Staffing Model: Utilizes existing on-call crews outside of regular full-time staff. To accommodate a transfer, a second crew must also be available. If the first crew performs a transfer, the second crew would be moved to regular activation pay while the first crew is unavailable. This model could work well in that the second crew is not receiving pay unless the first crew is performing a transfer.
- Paramedic Stipend Model: This model adds a $10 hourly pay stipend to any paramedic taking a transfer which requires paramedic level (Advanced Life Support) care. It must be noted that the typical increased reimbursement for ALS Non-Emergency from Medicare is $50.78 higher than BLS Non-Emergency btu does cover the extra expense of a paramedic.

Figure 13 below shows a formula which calculates the profitability of performing inter-facility ambulance transfers for Medicare patients. Appendix C provides additional detail and assumptions with this calculation.

Transfer Profitability Formula – Medicare BLS Non-Emergency to La Crosse

(First crew takes the transfer and are backfilled by EMTs at activation wages)

- **Revenue = (Medicare Base Rate Allowable) + (Loaded Miles*Mileage Allowable)**
  - **= $277.14 + ($63.8 * $8.80)**
  - **= $277.14 + $561.44**
  - **= $838.58**
- **Overall Expense = Labor Costs (backfill 911) + Fuel Cost + Supplies Cost + Vehicle Usage Cost + Misc. Costs**
  - **(See below) = $93.60 + $64.00 + $34.13 + $110 + $45.00**
  - **= $346.73**
- **Profit/(Loss) = Revenue – Expense**
  - **$491.85 for 2023**

Figure 13 – Sample ROI (Return on Investment) formula for a Medicare transfer from Wabasha to La Crosse.

Figure 14 examines the typical incremental transfer expenses while Figure 15 shows the profitability potential of typical ambulance transfers based upon the above recommended staffing models.

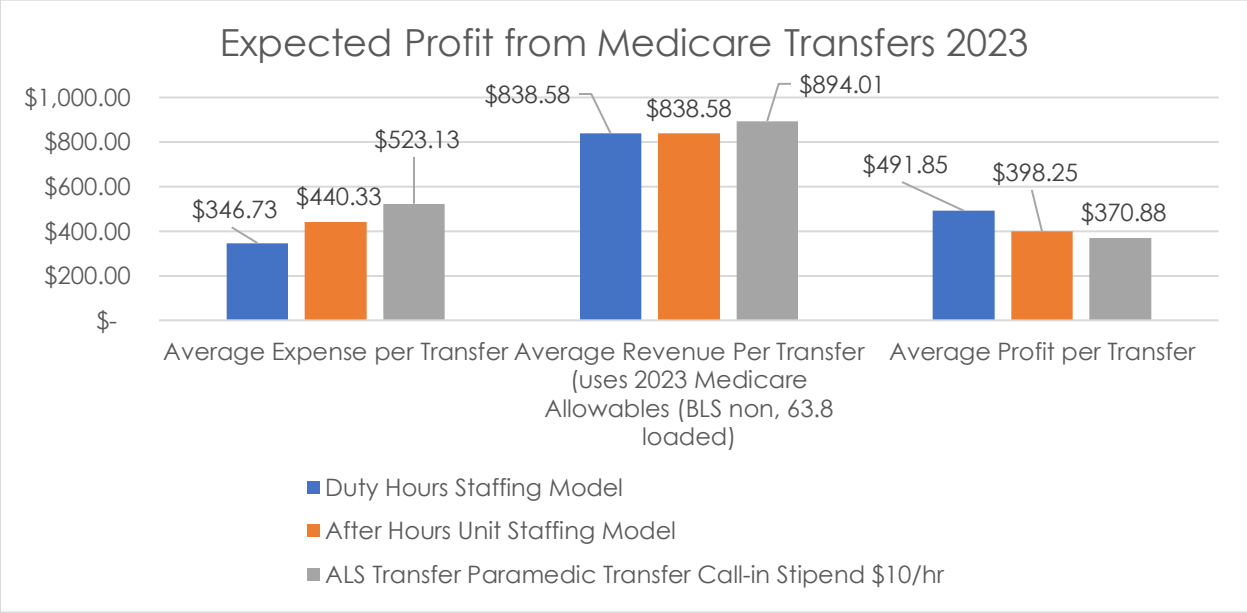

Figure 14 - Shows estimated revenue/expense/profit per transfer based upon direct costs and average payer mix.

When evaluating the potential to accept additional transfers from requesting hospitals, there are several factors which must be taken into consideration. Level of care, proper training, equipment to care for the patient, weather-related risks, and an assurance of payment for the trip. Operationally, WAS must also retain the ability to cover 911 requests

while the second ambulance is out of town on a transfer. Currently, when a transfer request is received, it is paged out to anyone eligible who is not already on-duty providing 911 coverage.

Of utmost importance in the inter-facility competitive market is communication with the hospitals who will be requesting WAS to provide the transfers. Assuming WAS is limiting the transfers they accept to Basic Life Support (BLS), a close working relationship with the hospitals will undoubtedly result in additional BLS transfer requests. Expectedly, most of the transfers outgoing from Gundersen St. Elizabeth's Hospital are at the ALS level. This limits the potential for WAS to accept additional transfers beyond ALS unless a paramedic were to be available.

If WAS were to staff a paramedic and upgrade their service level to Advanced Life Support, not only would it realize a slight bit more profitability for each individual transfer, but more so an increase in volume of transfers altogether.

Figure 16 below illustrates the potential for supplementary revenue (after direct expenses) by the number of additional transfers performed annually. The chart illustrates the potential maximum revenue for BLS and ALS transfers based upon fifty annual BLS transfers from Gundersen St. Elizabeth's annually and an additional 150 ALS transfers. Summarized, if WAS were able to provide ALS level service and accepted all transfers originating from Gundersen St. Elizabeth's annually, they could realize the potential for $70,000 to nearly $100,000 in transfer profits based upon the above recommended pay models. As a note, WAS could consider upgrading to a part-time ALS service with minimal cost and effort.

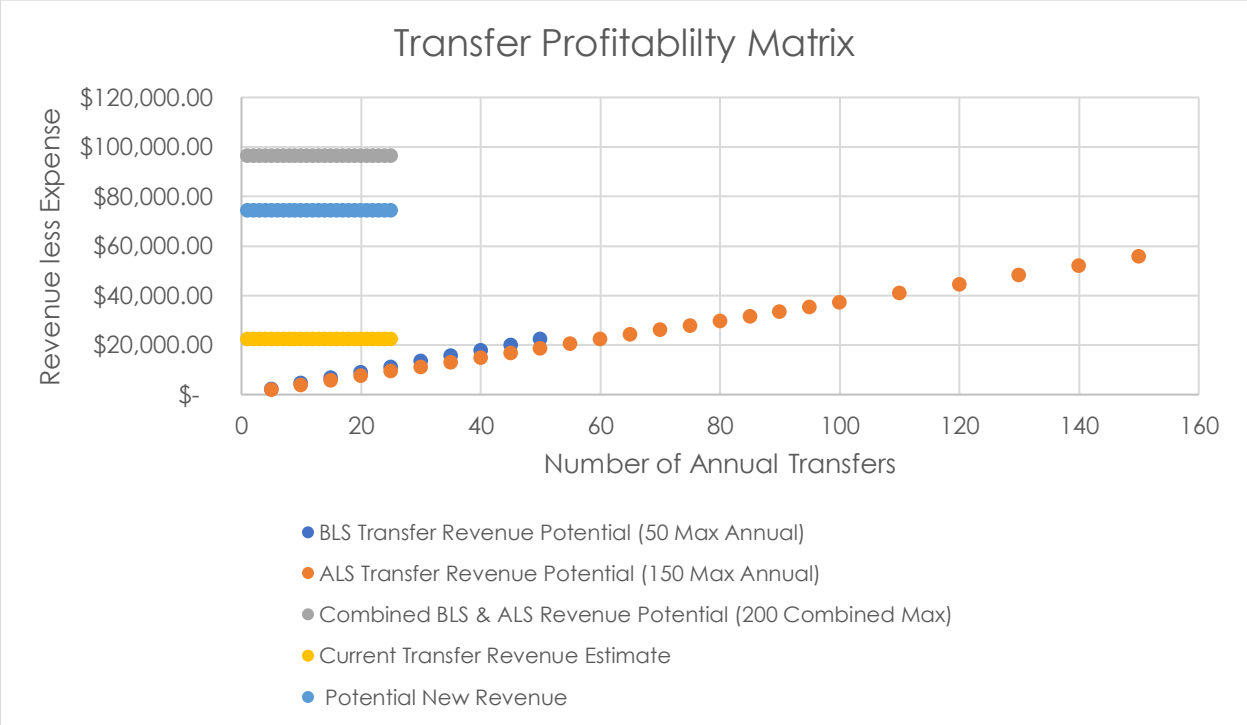

Figure 15 – Estimate of annual profitability through completion of additional transfers.

Revenue Increase Recommendations – Tax Assessments

The assurance of ambulance service for a community is universally considered as fundamental and necessary as is law enforcement and fire protection. It is common in Minnesota for municipally owned ambulance services to use taxation to help offset the cost of operating the service. Taxing bodies and rates as they relate to ambulance operations vary based upon the costs of operation, rurality or urbanicity, the service level (ALS or BLS), the payer mix, the labor market, and numerous other factors. Whether the assessment be a levied per capita charge to a municipality and the other governmental bodies it serves or through ad valorem tax districting, such revenue should be utilized by the City of Wabasha.

At present, the WAS budget deficits are offset by the City of Wabasha without financial support from the other six townships and one city it serves. While this arrangement has been longstanding and financially beneficial for the areas outside of Wabasha, a shared expense model should strongly be considered. One of the most common and equitable solutions to this dilemma is to introduce a per capita assessment in all areas served to offset WAS financial deficits.

In addition to the proposed assessment, the City of Wabasha will need to be diligent in their financial accounting practices regarding ambulance operations. It is recommended that the city consider classifying WAS as a separate business activity within the city oversight like how the water and sewer departments function. Operating WAS as a business activity with full accounting for revenue and expense activities will help ensure financial transparency and prevent conflict when setting per capita assessment rates.

The latest three-year average (2020 through projected 2022) operating loss for WAS is expected to be $187,691. This amount is equivalent to a $73.35 per capita assessment to the residents of the City of Wabasha. Table 9 below shows the projected subsidy required by the various political boundaries to offset this operating deficit. This operating loss does not include regular ambulance and equipment replacement costs which would be built into the business unit at the discretion of city leaders.

City/Town	Population	Percent of Population	Proposed per Capita Assessment	Contribution
Wabasha	2559	48.7%	$ 35.72	$ 91,398.91
Kellogg	415	7.9%	$ 35.72	$ 14,822.41
Greenfield Township	1308	24.9%	$ 35.72	$ 46,717.38
Pepin Township	313	6.0%	$ 35.72	$ 11,179.31
Glasgow Township	241	4.6%	$ 35.72	$ 8,607.71
Highland Township	81	1.5%	$ 35.72	$ 2,893.05
Watopa Township	160	3.0%	$ 35.72	$ 5,714.66
Minneiska Township	178	3.4%	$ 35.72	$ 6,357.56
Total Population	**5255**	**100.0%**		**$ 187,691.00**

Table 9 – The above proposed per capita assessments will allow for equitable financing of WAS.

Based on current and potential transfer and transport volumes, WAS will not be a profitable venture. Some stakeholders, it seems, may expect WAS to function without subsidy and using volunteer labor. The information provided to this consultant and processed in this analysis reveals otherwise.

Expense

The expenditures associated with operating WAS are accounted for as line items on the annual financial statements. As was found with the revenue portion, the City has been prudent in keeping the ambulance revenue and expense separate from the other city operations.

Capital Expense Planning

It seems from the budget documents received that there is a system for capital planning and purchasing. Capital planning requires careful consideration and capital budgets should continue to be updated at least annually. WAS utilizes a Capital Improvement Plan (CIP) which was most recently updated in the Fall of 2022. A well-designed capital purchasing plan, such as this CIP, will show full transparency to community stakeholders and prevent operating with outdated or unreliable equipment or vehicles. Furthermore, as the City begins to request financial participation from other areas, it will be prudent to include the other stakeholders in the CIP process.

Ambulance and Equipment Purchasing

Ambulance purchasing is typically the largest recurring capital expense an ambulance service will encounter. Historically, WAS has purchased ambulances in the $200,000 price range. Equipping an ambulance to be ready to respond requires additional purchases such as two-way radios, a mechanical CPR device, a heart monitor, a powered cot lifting system, and a power stretcher. These items combined can cost an additional $100,000.

Table 10 shows the most recent WAS Capital Improvement Plan created by the City of Wabasha.

City of Wabasha, Minnesota

Capital Improvement Plan

2023 thru 2032

PROJECTS BY FUNDING SOURCE

Source	#	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	Total
Borrowing												
Ambulance Expansion	24-AMB-01		289,000									289,000
Ambulance Doors and Windows	AMB D&W		22,000									22,000
Borrowing Total			**311,000**									**311,000**
Capital Improvement Fund												
Ambulance Roof	23-AMB-01	10,000										10,000
Replace 972	25-AMB-03			200,000								200,000
Two Lucas Devices	25-AMB-05		35,000									35,000
Two Monitors/AEDs	28-AMB-01						60,000					60,000
New Ambulance: 2030	30-AMB-01								300,000			300,000
Two Cots and Two Power Loads	30-AMB-02								50,000			50,000
Capital Improvement Fund Total		**10,000**	**35,000**	**200,000**			**60,000**		**350,000**			**655,000**
GRAND TOTAL		**10,000**	**346,000**	**200,000**			**60,000**		**350,000**			**966,000**

Table 10 – 2023-2032 Capital Improvement Plan.

Capital Recommendations

A capital expenditure/outlay plan must be created and adhered to. While ambulance purchases are the largest capital items, all depreciable hard assets should be reviewed at least annually.

- Ambulance equipment, including the ambulances themselves, should continue to be included in the annual Capital Improvement Plan and annualized as part of the business unit operations for the ambulance service. Once the plan is set, the expected costs could be accrued annually and added proportionally to the per capita assessment for all areas. City and town leaders may wish to consider segregating capital funds for future use in interest bearing accounts.
- The ambulance building should also continue to be included in the annual planning process. Building costs should also be annualized and included as financial expense to ensure fully accounted for operational costs.
- Ambulance capital lifespan is directly impacted by operations and best practices should be utilized to determine usable life. The present 12-year life span for WAS ambulances is reasonable based upon the response volume. A well-maintained ambulance can easily last 12-15 years and exceed 200,000 or more miles.
- A capital funding account could be established and accrued based upon the agreed upon annual schedule. The City may wish to segregate these funds once allotted to capital.
- WAS should continue to operate two ambulances but there is currently no need for a third.

Wages and Benefits

As is common with ambulance services, wages and benefits account for most operational expenditures. While smaller ambulance services, such as WAS, often utilize on-call staffing, it is important to benchmark wages and benefits against total expense (Table 11). This benchmark should be trended monthly and monitored to help ensure labor costs are within budget ranges. According to an analysis performed by the Minnesota Department of Health, the average personnel costs to total expense for Minnesota ambulance services was about 60% (Minnesota Department of Health, 2002). This comparison is important to understand as the costs associated with labor are discussed.

Wabasha Area Ambulance Service	2020 Actual	2021 Actual	2022 (Projected)	2023 Budget
Total Expense	$ 380,920.39	$ 389,827.43	$ 388,837.08	$ 399,787.76
Salaries/Wages	$ 213,374.43	$ 234,483.26	$ 227,399.01	$ 252,495.22
Insurance/PERA/Benefits	$ 53,090.28	$ 50,111.11	$ 39,954.68	$ 38,129.65
Social Security/Medicare	$ 11,323.41	$ 17,460.33	$ 11,323.41	$ 16,985.12
Work Comp	$ 12,561.50	$ 15,102.05	$ 24,349.97	$ 14,000.00
Total Wages and Benefits	$ 290,349.62	$ 317,156.75	$ 303,027.06	$ 321,609.99
Compensation Ratio	**76.2%**	**81.4%**	**77.9%**	**80.4%**
Benefits/Taxes as % of Wages	**36.1%**	**35.3%**	**33.3%**	**27.4%**

Table 11 – Compensation ratio for WAS based upon current staffing model.

As part of the analysis of the current wage and benefit structure of WAS, a few items of note are highlighted below:

- The current model utilizes a mix of full-time hourly employee and paid-on-call employees. The full-time staff typically work Monday through Friday 06:00 to 18:00.
- The EMS director role wage and benefit package does seem to align well with similarly sized municipal ambulance services.
- POC EMRs and EMTs are allowed 10 minutes in which to respond to the ambulance station when summoned to a 911 response. This requirement is like other ambulance services.
- In 2021, there are about fifteen employees of WAS who are on the roster.

The current pay structure for WAS is outlined below in Table 12.

2023 Wage Scale - FT EMTs					
$ 17.93	$ 18.29	$ 18.65	$ 19.42	$ 19.80	$ 20.20

WAS 2022 Wage rates (current)		
Job Role	Paid On Call	Hourly (when called in)
EMR	$ 4.00	$ 11.00
EMT	$ 6.00	$ 15.00

Table 12 - Pay rates as of 2022.

During the evaluation of WAS, it was obvious to this consultant that the City of Wabasha is aware that recruitment and retention of ambulance staff is paramount. It is also clear that there is a significant history relating to leadership staff turnover. While on the surface this may not appear to be a significant issue, strong and effective leadership of the ambulance service is of utmost importance to its healthy survival.

Each newly hired director in the past five to eight years has brought innovative ideas, fresh energy, and a willingness to improve the current state of WAS. Unfortunately, three directors have left the role within that same period. Although wages certainly play a pivotal role in the retention of leadership staff, it does not appear as though the directors' turnover was primarily impacted by the wage scale.

Determining Wages

Wages certainly play a significant role in the recruitment and retention of staff; however, it is important to understand and accept that pay alone will not solve the issue. With this thought, it must also be taken into thoughtful consideration as to what expectation employees feel is a fair pay rate. In the book *Drive*, the author performs a thorough analysis of employee motivation and discusses in detail the importance of intrinsic motivation (Pink, 2011). Pay is important, but not everything. When determining a fair pay rate, several factors should be taken into consideration:

- What are the pay rates of neighboring and similarly sized ambulance services? The staff of WAS know this and will think it unfair if paid less for the same work.

- What is an employee's time-off worth to them? Most WAS staff have full-time jobs and pick up shifts at WAS during their time off. As an example, how does one determine what "giving up" a Saturday morning with family or friends is worth?
- What benefits in addition to wages are available to staff?
- What other motivators are there at WAS? Do staff feel involved? Do staff feel valued by city officials and by the community? Is leadership supportive and helpful?

The current combination of POC (paid-on-call) and FT (full-time) staff is functional, but sustainability is questionable. Essentially, WAS assumes the theory through its experience that finding EMTs to staff weekday business hours is, at best, challenging. Through supplementing POC with FT staff, WAS has maintained adequate around-the-clock coverage.

As can be observed from Table 13 below, the current staffing and pay model fluctuates significantly based upon how frequently the POC hours are covered. This table is best interpreted as scenarios and potential labor cost exposure based upon actual wages and historical (2020-2022 YTD) data. Assumptions for Table 13 are as follows:

- On call staffed time assumes the percentage of time that one EMR and one EMT are staffed. 100% assumes one EMT and one EMR on call 24/7/365.
- Second call pay is paid to employees when either the first ambulance is already on a run or there is not anyone signed up for call and a crew responds. For this analysis, a 5% concurrent call rate will be used, and average activation pay of $13/hour to assume EMR/EMT backup crew.
- Labor assumes 911 responses while as a second out call/response are proportional to the percent of call time taken. In other words, due to limited data from past on-call sign-up times, this chart is not weighted for time of day 911 run volume fluctuations.
- Training and meeting hours are assumed to be paid out at an average of $20 per hour and 30 hours per employee per year.
- The table also uses a base labor cost of transfer of one hundred trips as this number seems attainable and was the average for 2020-2022 YTD.

Percent On Call Staffed	100%	90%	80%	70%	60%	50%
On Call and Activation Annual Cost (EMT/EMR)	$207,175.40	$200,416.10	$193,656.80	$186,897.50	$180,138.20	$173,378.90
Third Attendant Cost (20% of responses)	$ 5,596.50	$ 5,596.50	$ 5,596.50	$ 5,596.50	$ 5,596.50	$ 5,596.50
Second Call (times of no on-call/5% concurrent calls)	$ 794.43	$ 1,913.73	$ 3,033.03	$ 4,152.33	$ 5,271.63	$ 6,390.93
Manager Administrative Duties (24 weekly)	$ 40,800.00	$ 40,800.00	$ 40,800.00	$ 40,800.00	$ 40,800.00	$ 40,800.00
Training and Meeting Cost (15 employees/30 hours/yr)	$ 8,100.00	$ 8,100.00	$ 8,100.00	$ 8,100.00	$ 8,100.00	$ 8,100.00
Payroll taxes/minimal benefits/misc (22%)	$ 57,742.59	$ 56,501.79	$ 55,260.99	$ 54,020.19	$ 52,779.39	$ 51,538.59
Total 911 Coverage Expense	$320,208.92	$313,328.12	$306,447.32	$299,566.52	$292,685.72	$285,804.92
InterFacilty Transfer Direct Labor (`51.6 Transfers)	$ 9,659.52	$ 9,659.52	$ 9,659.52	$ 9,659.52	$ 9,659.52	$ 9,659.52
Total Annual Ambulance Labor	$329,868.44	$322,987.64	$316,106.84	$309,226.04	$302,345.24	$295,464.44

Percent On Call Staffed	40%	30%	20%	10%	0%
On Call and Activation Annual Cost (EMT/EMR)	$166,619.60	$159,860.30	$153,101.00	$146,341.70	$139,582.40
Third Attendant Cost (20% of responses)	$ 5,596.50	$ 5,596.50	$ 5,596.50	$ 5,596.50	$ 5,596.50
Second Call (times of no on-call/5% concurrent calls)	$ 7,510.23	$ 8,629.53	$ 9,748.83	$ 10,868.13	$ 11,987.43
Manager Administrative Duties (24 weekly)	$ 40,800.00	$ 40,800.00	$ 40,800.00	$ 40,800.00	$ 40,800.00
Training and Meeting Cost (15 employees/30 hours/yr)	$ 8,100.00	$ 8,100.00	$ 8,100.00	$ 8,100.00	$ 8,100.00
Payroll taxes/minimal benefits/misc (22%)	$ 50,297.79	$ 49,056.99	$ 47,816.19	$ 46,575.39	$ 45,334.59
Total 911 Coverage Expense	$278,924.12	$272,043.32	$265,162.52	$258,281.72	$251,400.92
InterFacilty Transfer Direct Labor (`51.6 Transfers)	$ 9,659.52	$ 9,659.52	$ 9,659.52	$ 9,659.52	$ 9,659.52
Total Annual Ambulance Labor	$288,583.64	$281,702.84	$274,822.04	$267,941.24	$261,060.44

Table 13 – Provides an estimate of labor costs utilizing the current POC model.

Wage and Benefit Summary

The staffing model WAS is currently using supplements FT (Full Time) staff with POC staff. While this model has been working and is affordable, there are concerns for its sustainability. As an example, a review of payroll reports shows that FT staff are picking up a fair number of evening and weekend hours due to inadequate POC coverage.

Operational Scenarios to Consider

Scenario 1 – Continue in Current State

This scenario with fiscal impact in Table 12, assumes the City of Wabasha wishes to remain in the business of running an ambulance service and continue current pay, staffing, and most equipment practices.

Key Points of Staffing Scenario 1:

- Continue with hourly ambulance director position, as is. Typically, 15-18 weekly hours of ambulance coverage time with the remainder spent dedicated to administrative work.
    - Key points currently in practice:
        - The director can work with the other three FT employees to provide 12-hour coverage Monday through Friday.
        - The director's hours may fluctuate based upon response volume and other factors such as FT employee coverage.
        - The director should continue to report to the city administrator.
- Enhance recruitment and retention efforts:
    - Work with area high schools to train and recruit new EMTs and EMRs.
    - Work to improve culture.
- Consider increasing Interfacility Transfers (IFT)
    - IFTs are profitable for WAS and should be pursued.
    - 911 coverage should not be placed at risk to provide IFT services.
    - Could include ALS paramedic transfers if upgraded to part-time ALS.

Advantages of Scenario 1

- Does not require immediate change.
- Minimal impact on current EMS staff.
- Ensures current level of response to 911.
- Additional revenue as compared to previous years by accepting and performing additional BLS transfers. An additional 20-40 transfers per year could be accepted.

Disadvantages of Scenario 1

- Does not prepare WAS for inevitable future staffing challenges.
- Does not look to share resources with other outside entities.

	Proposed Future Budget - Scenario 1			
Account Description	**2023**	**2024**	**2025**	**2026**
911 Annual Billable Responses (count/no growth)	325	325	325	325
Inter-Facility Annual Transports (count)	52	52	52	52
Basic Life Support Transfers	52	52	52	52
911 Transport Revenue (3% annual increased reimbursement)	$ 201,213.31	$ 207,249.71	$ 213,467.20	$ 219,871.22
IFT Transport Revenue (3% annual increased reimbursement)	$ 38,786.69	$ 39,950.29	$ 41,148.80	$ 42,383.26
R 100-34212 Ambulance Training Center Revenue	$ 500.00	$ 500.00	$ 500.00	$ 500.00
Grants and awards	$ 1,000.00	$ 1,000.00	$ 1,000.00	$ 1,000.00
Other				
Service Revenue	**$241,500**	**$248,700**	**$256,116**	**$263,754**
Expenses (3% base increase/+ proportional direct increases	**2023**	**2024**	**2025**	**2026**
E 100-420-42500-101 Full-time Employees-Regular	$ 169,495.22	$ 174,580.08	$ 179,817.48	$ 185,212.00
E 100-420-42500-103 Part-time Employees	$ 83,000.00	$ 85,490.00	$ 88,054.70	$ 90,696.34
E 100-420-42500-121 PERA Contributions	$ 12,562.14	$ 12,939.01	$ 13,327.18	$ 13,726.99
E 100-420-42500-122 FICA Contributions	$ 15,530.70	$ 15,996.62	$ 16,476.52	$ 16,970.82
E 100-420-42500-124 Medicare Contributions	$ 3,632.18	$ 3,741.15	$ 3,853.38	$ 3,968.98
E 100-420-42500-131 Health Insurance	$ 24,213.91	$ 24,940.33	$ 25,688.54	$ 26,459.20
E 100-420-42500-133 Dental Insurance	$ 481.92	$ 496.38	$ 511.27	$ 526.61
E 100-420-42500-134 Life Insurance	$ 871.68	$ 897.83	$ 924.77	$ 952.51
E 100-420-42500-140 UNEMPLOYEMENT TAXES	$ -	$ -	$ -	$ -
E 100-420-42500-151 Workers Comp Insurance Premium	$ 14,000.00	$ 14,420.00	$ 14,852.60	$ 15,298.18
E 100-420-42500-200 Office Supplies	$ 500.00	$ 515.00	$ 530.45	$ 546.36
E 100-420-42500-206 Training Center Expenditures	$ 2,000.00	$ 2,060.00	$ 2,121.80	$ 2,185.45
E 100-420-42500-212 Motor Fuels	$ 3,000.00	$ 3,090.00	$ 3,182.70	$ 3,278.18
E 100-420-42500-215 Oxygen-Supplies	$ 1,000.00	$ 1,030.00	$ 1,060.90	$ 1,092.73
E 100-420-42500-217 Medical Supplies	$ 10,000.00	$ 10,300.00	$ 10,609.00	$ 10,927.27
E 100-420-42500-219 General Supplies	$ 1,500.00	$ 1,545.00	$ 1,591.35	$ 1,639.09
E 100-420-42500-221 Equipment Maintenance/Parts	$ 4,000.00	$ 4,120.00	$ 4,243.60	$ 4,370.91
E 100-420-42500-223 Building Maint/Repair Supplies	$ 1,000.00	$ 1,030.00	$ 1,060.90	$ 1,092.73
E 100-420-42500-308 Continuing Ed	$ 6,000.00	$ 6,180.00	$ 6,365.40	$ 6,556.36
E 100-420-42500-310 First Respondors	$ 1,000.00	$ 1,030.00	$ 1,060.90	$ 1,092.73
E 100-420-42500-311 Contractor Fees	$ 16,500.00	$ 16,995.00	$ 17,504.85	$ 18,030.00
E 100-420-42500-312 Computer Support	$ -	$ -	$ -	$ -
E 100-420-42500-321 Telephone	$ 2,500.00	$ 2,575.00	$ 2,652.25	$ 2,731.82
E 100-420-42500-322 Postage	$ 50.00	$ 51.50	$ 53.05	$ 54.64
E 100-420-42500-331 Travel Expense	$ 1,000.00	$ 1,030.00	$ 1,060.90	$ 1,092.73
E 100-420-42500-350 Printing and Binding	$ 500.00	$ 515.00	$ 530.45	$ 546.36
E 100-420-42500-361 General Liability/Property Ins	$ 5,000.00	$ 5,150.00	$ 5,304.50	$ 5,463.64
E 100-420-42500-365 AMB/FIRE DISABILITY ACCIDENT	$ 3,000.00	$ 3,090.00	$ 3,182.70	$ 3,278.18
E 100-420-42500-381 Electric/Gas Utility	$ 2,500.00	$ 2,575.00	$ 2,652.25	$ 2,731.82
E 100-420-42500-401 Building Contract Maintenance	$ 1,000.00	$ 1,030.00	$ 1,060.90	$ 1,092.73
E 100-420-42500-409 Maintenance Agreements	$ 750.00	$ 772.50	$ 795.68	$ 819.55
E 100-420-42500-414 Vehicle Maintenance	$ 3,500.00	$ 3,605.00	$ 3,713.15	$ 3,824.54
E 100-420-42500-430 Miscellaneous	$ 2,000.00	$ 2,060.00	$ 2,121.80	$ 2,185.45
E 100-420-42500-433 Dues and Subscriptions	$ 1,200.00	$ 1,236.00	$ 1,273.08	$ 1,311.27
E 100-420-42500-436 Insurance Deductible for Claim	$ -	$ -	$ -	$ -
E 100-420-42500-437 Misc Licenses and Permits	$ 500.00	$ 515.00	$ 530.45	$ 546.36
E 100-420-42500-570 Office Equipment & Furnishings	$ 1,000.00	$ 1,030.00	$ 1,060.90	$ 1,092.73
E 100-420-42500-581 Uniforms	$ 3,000.00	$ 3,090.00	$ 3,182.70	$ 3,278.18
E 100-420-42500-582 Radio Equipment	$ 2,000.00	$ 2,060.00	$ 2,121.80	$ 2,185.45
Total Operating Expense	$ 399,787.76	$ 411,781.39	$ 424,134.83	$ 436,858.88
Profit/(Loss) from Operations	**$ (159,287.76)**	**$ (163,081.39)**	**$ (168,018.83)**	**$ (173,104.40)**
Estimated Subsidy to Cover Expenses	$ 159,287.76	$ 163,081.39	$ 168,018.83	$ 173,104.40

Table 14 – Shows estimated financial performance of "Scenario 1" operational model.

Scenario 2 Considerations – Utilize Paramedics or A-EMTs for transfers. Increases backfill wages.

This scenario assumes the City of Wabasha wishes to remain in the business of running an ambulance service and increase revenue without proportionally increasing expense. While only the current director is trained at the paramedic level, there could be an opportunity to increase existing staff training to Advanced EMT. When combined with existing clinical practice variances, doing so would allow WAS to accept, perform, and bill ALS for additional transfers out of Gundersen St. Elizabeth's Hospital.

Key Points of Scenario 2:

- Work with existing FT and POC staff to consider upgrading certification level to the AEMT (Advanced Emergency Medical Technician). Although the EMSRB does not recognize the AEMT as a license/certification level, it is required at a minimum to be reimbursed by Medicare at the ALS level. Medicaid and commercial payers follow suit and will also typically reimburse AEMT and above at the ALS level. A combination of AEMT and additional variances, as allowed, will increase the ability to perform additional transfers.
- Consider working with existing nurses on staff to perform ALS transfers if allowed by the EMSRB.
- Increase hourly wage for hospital transfers to incentivize this increased training while also increasing the way backfill wage incentive.
- Increase EMR Activation/On-Duty pay
    - Increase from $11.00/hour to $13.00/hour. Impact on expenses will be less than $1,000 per year.
- Modify Second Out Pay Practice during Transfers
    - When a transfer is accepted which will last greater than one hour, consider creating a second out "Transfer Coverage" schedule item. EMTs and EMRs who provide this coverage during a transfer could receive their prevailing on-duty pay while the first ambulance is out of the area and unavailable.
    - This incentive could help increase backup coverage, which will allow WAS to accept additional transfers.
- Provide AEMT and Paramedic Stipend
    - To encourage AEMT and paramedic staff when not on duty to accept transfers, consider an additional $10.00/hour transfer stipend fee.
- Interfacility Transfer Notes (IFT)
    - IFTs are profitable for WAS and should be pursued.
    - 911 coverage should not be placed at risk to provide IFT services.
    - A typical IFT is projected to result in a realized profit.

Advantages of Scenario 2

- Brings WAS in-line with similar ambulance services as it relates to on-call and duty pay.
- Uses increased transfer volume and ALS charges to help offset increases to incentive pay
- Provides incentive to respond to ambulance calls with higher duty pay.
- Ensures quick response to 911 calls and reliability with second out calls.

Disadvantages of Scenario 2

- Budget relies heavily on inter-facility transport to help offset financial losses. Increases or decreases in transfer volume will impact the amount of financial subsidy needed.

	Proposed Future Budget - Scenario 2			
Account Description	**2023**	**2024**	**2025**	**2026**
911 Annual Billable Responses (count/no growth)	325	325	325	325
Inter-Facility Annual Transports (count/30% annual growth in ALS)	68	81	97	117
Basic Life Support Transfers	52	52	52	52
Advanced Life Support Transfers	16	29	45	65
911 Transport Revenue (3% annual increased reimbursement)	$ 189,349.15	$ 195,029.62	$ 200,880.51	$ 206,906.93
IFT Transport Revenue (3% annual increased reimbursement)	$ 50,650.85	$ 62,761.12	$ 75,470.01	$ 90,720.68
R 100-34212 Ambulance Training Center Revenue	$ 500.00	$ 500.00	$ 500.00	$ 500.00
Grants and awards	$ 1,000.00	$ 1,000.00	$ 1,000.00	$ 1,000.00
Other				
Service Revenue	**$241,500**	**$259,291**	**$277,851**	**$299,128**
Expenses (3% base increase/+ proportional direct increases)	**2023**	**2024**	**2025**	**2026**
Increased EMR On-Call Pay	$ 5,000.00	$ 5,150.00	$ 5,304.50	$ 5,463.64
Increased Direct Labor and Non-Labor Costs of Additional Volume	$ 7,634.64	$ 14,678.87	$ 22,857.09	$ 32,670.97
E 100-420-42500-101 Full-time Employees-Regular	$ 169,495.22	$ 174,580.08	$ 179,817.48	$ 185,212.00
E 100-420-42500-103 Part-time Employees	$ 83,000.00	$ 85,490.00	$ 88,054.70	$ 90,696.34
E 100-420-42500-121 PERA Contributions	$ 12,562.14	$ 12,939.01	$ 13,327.18	$ 13,726.99
E 100-420-42500-122 FICA Contributions	$ 15,530.70	$ 15,996.62	$ 16,476.52	$ 16,970.82
E 100-420-42500-124 Medicare Contributions	$ 3,632.18	$ 3,741.15	$ 3,853.38	$ 3,968.98
E 100-420-42500-131 Health Insurance	$ 24,213.91	$ 24,940.33	$ 25,688.54	$ 26,459.20
E 100-420-42500-133 Dental Insurance	$ 481.92	$ 496.38	$ 511.27	$ 526.61
E 100-420-42500-134 Life Insurance	$ 871.68	$ 897.83	$ 924.77	$ 952.51
E 100-420-42500-140 UNEMPLOYEMENT TAXES	$ -	$ -	$ -	$ -
E 100-420-42500-151 Workers Comp Insurance Premium	$ 14,000.00	$ 14,420.00	$ 14,852.60	$ 15,298.18
E 100-420-42500-200 Office Supplies	$ 500.00	$ 515.00	$ 530.45	$ 546.36
E 100-420-42500-206 Training Center Expenditures	$ 2,000.00	$ 2,060.00	$ 2,121.80	$ 2,185.45
E 100-420-42500-212 Motor Fuels	$ 3,000.00	$ 3,090.00	$ 3,182.70	$ 3,278.18
E 100-420-42500-215 Oxygen-Supplies	$ 1,000.00	$ 1,030.00	$ 1,060.90	$ 1,092.73
E 100-420-42500-217 Medical Supplies	$ 10,000.00	$ 10,300.00	$ 10,609.00	$ 10,927.27
E 100-420-42500-219 General Supplies	$ 1,500.00	$ 1,545.00	$ 1,591.35	$ 1,639.09
E 100-420-42500-221 Equipment Maintenance/Parts	$ 4,000.00	$ 4,120.00	$ 4,243.60	$ 4,370.91
E 100-420-42500-223 Building Maint/Repair Supplies	$ 1,000.00	$ 1,030.00	$ 1,060.90	$ 1,092.73
E 100-420-42500-308 Continuing Ed	$ 6,000.00	$ 6,180.00	$ 6,365.40	$ 6,556.36
E 100-420-42500-310 First Respondors	$ 1,000.00	$ 1,030.00	$ 1,060.90	$ 1,092.73
E 100-420-42500-311 Contractor Fees	$ 16,500.00	$ 16,995.00	$ 17,504.85	$ 18,030.00
E 100-420-42500-312 Computer Support	$ -	$ -	$ -	$ -
E 100-420-42500-321 Telephone	$ 2,500.00	$ 2,575.00	$ 2,652.25	$ 2,731.82
E 100-420-42500-322 Postage	$ 50.00	$ 51.50	$ 53.05	$ 54.64
E 100-420-42500-331 Travel Expense	$ 1,000.00	$ 1,030.00	$ 1,060.90	$ 1,092.73
E 100-420-42500-350 Printing and Binding	$ 500.00	$ 515.00	$ 530.45	$ 546.36
E 100-420-42500-361 General Liability/Property Ins	$ 5,000.00	$ 5,150.00	$ 5,304.50	$ 5,463.64
E 100-420-42500-365 AMB/FIRE DISABILITY ACCIDENT	$ 3,000.00	$ 3,090.00	$ 3,182.70	$ 3,278.18
E 100-420-42500-381 Electric/Gas Utility	$ 2,500.00	$ 2,575.00	$ 2,652.25	$ 2,731.82
E 100-420-42500-401 Building Contract Maintenance	$ 1,000.00	$ 1,030.00	$ 1,060.90	$ 1,092.73
E 100-420-42500-409 Maintenance Agreements	$ 750.00	$ 772.50	$ 795.68	$ 819.55
E 100-420-42500-414 Vehicle Maintenance	$ 3,500.00	$ 3,605.00	$ 3,713.15	$ 3,824.54
E 100-420-42500-430 Miscellaneous	$ 2,000.00	$ 2,060.00	$ 2,121.80	$ 2,185.45
E 100-420-42500-433 Dues and Subscriptions	$ 1,200.00	$ 1,236.00	$ 1,273.08	$ 1,311.27
E 100-420-42500-436 Insurance Deductible for Claim	$ -	$ -	$ -	$ -
E 100-420-42500-437 Misc Licenses and Permits	$ 500.00	$ 515.00	$ 530.45	$ 546.36
E 100-420-42500-570 Office Equipment & Furnishings	$ 1,000.00	$ 1,030.00	$ 1,060.90	$ 1,092.73
E 100-420-42500-581 Uniforms	$ 3,000.00	$ 3,090.00	$ 3,182.70	$ 3,278.18
E 100-420-42500-582 Radio Equipment	$ 2,000.00	$ 2,060.00	$ 2,121.80	$ 2,185.45
Total Operating Expense	$ 412,422.40	$ 431,610.26	$ 452,296.43	$ 474,993.48
Profit/(Loss) from Operations	**$ (170,922.40)**	**$ (172,319.52)**	**$ (174,445.90)**	**$ (175,865.87)**
Estimated Subsidy to Cover Expenses	$ (170,922.40)	$ (172,319.52)	$ (174,445.90)	$ (175,865.87)

Table 15 – Shows estimated financial status of "Scenario 2" operational model.

Scenario 3 – Move to Full-Time/Career Ambulance Service

This scenario assumes the City of Wabasha would like to staff their ambulance service with full-time, benefit eligible employees. This would require at least 6.5, 56-hour/week employees or over 10, 36 hour/week employees.

Key Points of Scenario 3:

- A reliable staffing model assuming adequate labor market for EMTs and EMRs but would encourage staffing of one paramedic per shift to increase transfer ability.
- Most responsive model as ambulances could respond to calls in less than 1-2 minutes based on proximity to the station.
- Most expensive model and would require significant operating subsidy.
- Unless full-time staff live locally and are willing to respond off-duty, it would require additional staff or incentives for remaining POC staff for second call and/or transfer coverage.

Advantages of Scenario 3

- Responsive and manageable.
- Theoretically more reliable than the other models.
- Lower staff numbers equate to higher levels of experience through increased patient contacts.

Disadvantages of Scenario 3

- Cost prohibitive.
- Would drastically increase per capita contributions to the Ambulance Service Fund. Could be close to $90.00.

	Proposed Future Budget - Scenario 3			
Account Description	**2023**	**2024**	**2025**	**2026**
911 Annual Billable Responses (count/no growth)	325	325	325	325
Inter-Facility Annual Transports (count/30% annual growth in ALS)	68	81	97	117
Basic Life Support Transfers	52	52	52	52
Advanced Life Support Transfers	16	29	45	65
911 Transport Revenue (3% annual increased reimbursement)	$ 189,349.15	$ 195,029.62	$ 200,880.51	$ 206,906.93
IFT Transport Revenue (3% annual increased reimbursement)	$ 50,650.85	$ 62,761.12	$ 75,470.01	$ 90,720.68
R 100-34212 Ambulance Training Center Revenue	$ 500.00	$ 500.00	$ 500.00	$ 500.00
Grants and awards	$ 1,000.00	$ 1,000.00	$ 1,000.00	$ 1,000.00
Other				
Service Revenue	**$241,500**	**$259,291**	**$277,851**	**$299,128**
Expenses (3% base increase/+ proportional direct increases)	**2023**	**2024**	**2025**	**2026**
E 100-420-42500-101 Full-time Employees-Regular	$ 399,360.00	$ 411,340.80	$ 423,681.02	$ 436,391.45
Administrative portion of director salary	$ 33,280.00	$ 34,278.40	$ 35,306.75	$ 36,365.95
Part-time and POC Employees	$ 35,000.00	$ 36,050.00	$ 37,131.50	$ 38,245.45
E 100-420-42500-121 PERA Contributions	$ 25,124.28	$ 25,878.01	$ 26,654.35	$ 27,453.98
E 100-420-42500-122 FICA Contributions	$ 34,167.55	$ 35,192.57	$ 36,248.35	$ 37,335.80
E 100-420-42500-124 Medicare Contributions	$ 7,990.80	$ 8,230.52	$ 8,477.44	$ 8,731.76
E 100-420-42500-131 Health Insurance	$ 53,270.61	$ 54,868.72	$ 56,514.79	$ 58,210.23
E 100-420-42500-133 Dental Insurance	$ 1,060.22	$ 1,092.03	$ 1,124.79	$ 1,158.54
E 100-420-42500-134 Life Insurance	$ 1,917.70	$ 1,975.23	$ 2,034.48	$ 2,095.52
E 100-420-42500-140 UNEMPLOYEMENT TAXES	$ -	$ -	$ -	$ -
E 100-420-42500-151 Workers Comp Insurance Premium	$ 30,800.00	$ 31,724.00	$ 32,675.72	$ 33,655.99
E 100-420-42500-200 Office Supplies	$ 500.00	$ 515.00	$ 530.45	$ 546.36
E 100-420-42500-206 Training Center Expenditures	$ 2,000.00	$ 2,060.00	$ 2,121.80	$ 2,185.45
E 100-420-42500-212 Motor Fuels	$ 3,000.00	$ 3,090.00	$ 3,182.70	$ 3,278.18
E 100-420-42500-215 Oxygen-Supplies	$ 1,000.00	$ 1,030.00	$ 1,060.90	$ 1,092.73
E 100-420-42500-217 Medical Supplies	$ 10,000.00	$ 10,300.00	$ 10,609.00	$ 10,927.27
E 100-420-42500-219 General Supplies	$ 1,500.00	$ 1,545.00	$ 1,591.35	$ 1,639.09
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E 100-420-42500-310 First Respondors	$ 1,000.00	$ 1,030.00	$ 1,060.90	$ 1,092.73
E 100-420-42500-311 Contractor Fees	$ 16,500.00	$ 16,995.00	$ 17,504.85	$ 18,030.00
E 100-420-42500-312 Computer Support	$ -	$ -	$ -	$ -
E 100-420-42500-321 Telephone	$ 2,500.00	$ 2,575.00	$ 2,652.25	$ 2,731.82
E 100-420-42500-322 Postage	$ 50.00	$ 51.50	$ 53.05	$ 54.64
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E 100-420-42500-361 General Liability/Property Ins	$ 5,000.00	$ 5,150.00	$ 5,304.50	$ 5,463.64
E 100-420-42500-365 AMB/FIRE DISABILITY ACCIDENT	$ 3,000.00	$ 3,090.00	$ 3,182.70	$ 3,278.18
E 100-420-42500-381 Electric/Gas Utility	$ 2,500.00	$ 2,575.00	$ 2,652.25	$ 2,731.82
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E 100-420-42500-436 Insurance Deductible for Claim	$ -	$ -	$ -	$ -
E 100-420-42500-437 Misc Licenses and Permits	$ 500.00	$ 515.00	$ 530.45	$ 546.36
E 100-420-42500-570 Office Equipment & Furnishings	$ 1,000.00	$ 1,030.00	$ 1,060.90	$ 1,092.73
E 100-420-42500-581 Uniforms	$ 3,000.00	$ 3,090.00	$ 3,182.70	$ 3,278.18
E 100-420-42500-582 Radio Equipment	$ 2,000.00	$ 2,060.00	$ 2,121.80	$ 2,185.45
Total Operating Expense	$ 697,971.16	$ 718,910.29	$ 740,477.60	$ 762,691.93
Profit/(Loss) from Operations	**$ (456,471.16)**	**$ (459,619.55)**	**$ (462,627.07)**	**$ (463,564.32)**
Estimated Subsidy to Cover Expenses	$ (456,471.16)	$ (459,619.55)	$ (462,627.07)	$ (463,564.32)

Figure 16 - Shows estimated financial status of "Scenario 3" operational model.

The Value of Volunteer Labor

Of special note is the fact that by using POC/Volunteer staff to provide on-call coverage for 11,280 hours annually, the City of Wabasha is saving in the neighborhood $150,000 per year.

Summary of Scenarios

The above three scenarios are intended to give the City of Wabasha an idea of a few staffing models and their potential financial and reliability impact. Certainly, there are many more potential operating models than these three, but these examples should help with the formulation of a recommendation.

Staff Development Costs

Emergency medical technicians and Emergency Medical Responders, in addition to their initial education and training, are required to maintain educational components to renew their certifications every two years. In general, and on average, EMTs need 30 hours of continuing education annually. Fortunately, the State of Minnesota typically reimburses some types of training and educational components. There has not been reported financial training funds reimbursed to WAS.

Examining and analyzing the various components related to the educational programs offered by WAS is out of scope for this financial analysis. However, in the recommended labor estimate, 2.5 hours of monthly meetings have been included in the budget (Table 16). These hours should be sufficient, in relation to costs, to compensate up to fifteen staff their time while in training meetings.

Description	Number of Staff	Monthly Hours	Annual Hours	Avg Cost per Employee per Hour	Annual Cost
Staff Development/Training	15	2.5	30	$ 22.50	$10,125.00

Table 16 – Estimated costs related to training. Does not include taxes/benefits in this table.

Purchasing

WAS works with area ambulance services to attempt to buy in quantity. The current rates observed from sample pricing were adequate and competitive. WAS should also consider utilizing purchasing groups such as the non-profit EMS buying group, SAVVIK.

Overall Financial Summary

The Wabasha Ambulance Service has certainly seen its struggles in the past few years. With new ambulance leadership oversight and engaged city leadership, the stage is set for improvement. The very fact that the City of Wabasha has requested this assessment shows their interest in learning more and eventual improvement.

Trust must be established and fostered between the City and the area townships within the WAS PSA (Primary Service Area) as there will be a continued need for financial support from all parties.

Major Financial Recommendations (Reiterated and Summarized)

Revenue and Billing

1. *There are many older patient accounts moved from the previous billing service to the current vendor. Many of these accounts have significant outstanding balances*

and extra attention should be given to collecting on them. Unfortunately, it is likely that many of these older accounts have gone beyond timely filing requirements.

2. *WAS does not currently have an agreement with a collection agency. Utilizing a collection agency in addition to the billing agency will provide additional methods in which self-pay accounts will be reimbursed. This is a high priority recommendation as there is more than $50,000 of self-pay accounts older than 6 months. It is common for a collection agency to recover 15-30% of write-offs.*
3. *Minnesota Revenue Recapture is not utilized by WAS and should be. The process is free, simple to use, and could be done routinely. It is common to recover between 5% and 10% of self-pay accounts previously deemed uncollectable.*
4. *Ensure that the ePCR documentation is completed in full by the ambulance crew on the call. Any additions or addendums related to patient care must be documented by and signed by the attending crew.*
5. *The internal WAS billing account spreadsheet must be kept updated regularly and reconciled monthly with the billing company. The worksheet should separate out the base rate and the mileage charges. This worksheet is the core account record that the city has and must be kept current.*
6. *Monitor ePCR completion with a goal of having at least 90% of the written reports completed within one hour of the call (back at the station) and 100% within two hours.*
7. *Establish a monthly meeting with the billing company in which the ambulance manager, city administrator, and city financial administrator, review the previous month's revenue and collections activity.*
8. *Establish a monthly meeting with the billing company in which the ambulance manager and financial manager review the previous month's revenue and collections activity.*
9. *The billing company should include a payer mix trend in its monthly reports to WAS. This report should be based upon the primary payer. Trend payer mixes over time is important to high-level planning and budgeting processes.*
10. *The billing company currently includes a payer mix trend in its monthly reports to WAS. This report should be aggregated toward annual trends as monthly run volumes are small resulting in larger fluctuations.*
11. *Additional efforts should be made to recover accounts that are patient responsibility. While these accounts are typically more difficult to collect, WAS collection rates from the time of this study have no revenue. This component ties closely with the lack of a collection agency and lack of utilizing MN Revenue Recapture.*
12. *Twelve ambulance transports in the most recent one-year period were for patients with primary insurance coverage of Blue Cross/Blue Shield (BCBS) commercial coverage. WAS does not have an agreement with BCBS to discount their rates but has reduced some accounts. Some commercial payers will inform ambulances services that they must accept their full payment at a less than billed rate. WAS should work directly with patients to ensure claims are paid in full.*

13. *Immediately prepare for and begin reporting data to CMS as part of the required data collection initiative. WAS must collect data for CY (Calendar Year) 2022 and report in CY 2023. Please reference www.ambulancereports.org and the Medicare website for more information.*
14. *WAS should participate in the Supplemental Medical Assistance payments program through the MN DOR. It does not appear as though WAS has submitted to this program and doing so could return several thousand dollars annually.*
15. *WAS should meet with their billing agency regularly with a special annual meeting, typically in the fourth quarter, to establish billing rates for the following year.*
16. *When developing a relationship and contract between a collection agency and Wabasha, it should include, at a minimum:*
    a. *Letter writing service. This is a letter that goes out from the collection agency to the delinquent account owner stating that the account is now in collections and gives the party 30 days (about four and a half weeks) to pay or plan before the account goes to credit reporting. This service is commonplace and can be included for a small fee.*
    b. *A Business Associate Agreement (BAA) should be signed by both entities stating that they will be sharing information for billing practices.*
    c. *A flat fee or commission both entities can agree upon.*
17. *Ensure that WAS and the billing company mutually develop a policy which determines when delinquent accounts are transferred to a collection agency (once established).*

General Accounting and Financial Practices

18. *Consider the ambulance operations to be treated as a "Business-Type Activity" for purposes of financial accounting. All revenue and expenses associated with ambulance operations should be accounted for under a separate accounting unit, away from general or other fund activities. This would include annual depreciation expensing of capital assets. Proper accounting will ensure proper tax assessment and allow funding for future capital purchases.*
19. *The City of Wabasha, primarily due to necessity, is in the business of operating an ambulance service and all towns and cities withing the WAS PSA could contribute financially. Tax assessments for all areas where WAS provides service should strongly be considered. A table and increase consideration can be found in the report.*
20. *A capital expenditure/outlay plan must be created and adhered to. While ambulance purchases are the largest capital items, all depreciable hard assets should be reviewed at least annually.*
    a. *Ambulance equipment, including the ambulances themselves, should continue to be included in the annual Capital Improvement Plan and annualized as part of the business unit operations for the ambulance service. Once the plan is set, the expected costs should be accrued annually and added proportionally to the per capita assessment for all*

areas. City and town leaders may wish to consider segregating capital funds for future use in interest bearing accounts.

b. *The ambulance building should also continue to be included in the annual planning process. Building costs should also be annualized and included as financial expense to ensure fully accounted for operational costs.*
c. *Ambulance capital lifespan is directly impacted by operations and best practices should be utilized to determine usable life. The present 12-year life span for WAS ambulances is reasonable based upon the response volume. A well-maintained ambulance can easily last 12-15 years and exceed 200,000 or more miles.*
d. *A capital funding account should be established and accrued based upon the agreed upon annual schedule. The City may wish to segregate these funds once allotted to capital.*
e. *WAS should continue to operate two ambulances but there is currently no need for a third.*

Labor and Staffing

21. *Consider formalizing the ambulance director position and aligning with other city leadership positions. The director position should consider key points addressed in Scenario 2 of this document.*
22. *Consider increasing activation pay of EMR to $13.00/hour from $11.00/hour. While only a handful of EMRs are on staff, they are needed and should be encouraged to pick up hours.*
23. *The building used for staff seems reasonable but could use improvement. WAS should be mindful to ensure on-call staff are free to go about their personal lives while on call.*

OPERATIONS AND RESPONSE CONSIDERATIONS

Overview

"When you've seen one EMS system, you've seen one EMS system." While this statement can certainly be made of other industries, it is very fitting for EMS and more specifically for ambulance services. The type of ownership and control of ambulance services such as private, public, for-profit, non-for-profit, governmentally owned (such as WAS), fire department based, hospital owned, hospital based, and combinations of these, varies. Full-time career staffing is typically the norm in busier EMS systems where run volume dictates the need for dedicated in-house staff. In smaller EMS systems, such as WAS, volunteer and/or paid-on-call labor is commonplace. Regardless of the type of business structure and staffing model used, 911 ambulance services, such as WAS, must strive for the objective of ensuring the communities in which they serve have an adequate and responsive EMS system.

To meet this objective, numerous factors must be considered. At part of this assessment, the following core operational areas will be reviewed and discussed:

- Staffing and schedule coverage
- Response times to life-threatening emergencies
- Service area and potential growth

Staffing and Schedule Coverage

At the time of this writing this assessment and for the past few years, the WAS staffing model and core functionality is as follows:

- One (1) full-time ambulance director.
- Three (3) full-time benefit eligible employees. These full-time staff are intended to work a core schedule of Monday through Friday from 6:00 a.m. to 6:00 p.m. each day.
- The remaining hours are filled with a combination of POC EMTs and EMRs. In 2021, which was the last full year of data, there were 16 POC staff who regularly signed up for on-call.

This staffing model allows the director a proportion of time dedicated to administrative duties where he or she is not considered part of the primary ambulance response. In a typical week, this could be as many as 20 hours or as little as zero hours depending on the other full-time employee schedules and time off. This full-time staff, when scheduled as planned, provides annual coverage of 3,120 ambulance hours out of the possible 8,760 hours required to staff one ambulance 24/7/365. This means that 5,640 hours of ambulance coverage is expected to be staffed by the POC staff. Since it requires at least two ambulance attendants to staff an ambulance, one driver and one caregiver, the number of staff hours to provide this coverage is doubled. Based on 16 POC staff use, Table 17 below shows the average number of aggregate hours POC staff would need to work to fully supplement the full-time employees. In other words, if all POC hours were spread equally amongst the 16 POC staff, the table shows how many hours each would need to cover to have around clock coverage. Also included in this table is a cutoff level for critical staffing and recommended POC staffing numbers.

11,280 Annual Hours of On-Call Coverage Needed to Fill Evening and Weekend Hours (minimum 2 people on call)			
	Average On-Call Hours Needed per Voluntee		
Number of Paid-On-Call Staff on Roster	Weekly	Monthly	Annually
1 (cannot staff ambulance with 1 person)	NA	NA	NA
2	108	470	5640
3	72	313	3760
4	54	235	2820
5	43	188	2256
6	36	157	1880
7	31	134	1611
8	27	118	1410
9	24	104	1253
10	22	94	1128
11	20	85	1025
12	18	78	940
13	17	72	868
14	15	67	806
15	14	63	752
16 (Wabasha 2021)	14	59	705
17	13	55	664
18	12	52	627
19	11	49	594
20	11	47	564
21	10	45	537
22	10	43	513
23	9	41	490
24 (Recommended Level)	9	39	470

Table 17 – Theoretical average hours of POC per EMT/EMR needed to supplement full-time staff.

The 2021 POC staff statistics are shown in Table 18. Additional information in Figures 16 & 17 below assume 16 POC members for the entire year of 2021. It appears from data provided that the on-call hours discrepancy between the required 705 hours and the actual average of 629 hours is often filled by full-time employees on overtime wages. For this, and many other reasons, the value of POC staff to WAS should not be underestimated.

2021 Paid on Call Statistics (Assumes 16 POC Staff)	Hours On-Call
Average POC On-Call Hours per Staff Member	629
Median POC On-Call Hours per Staff Member	639
Maximum POC On-Call Hours by a Staff Member	1229
Minimum POC On-Call Hours by a Staff Member	2
Average POC On-Call Hours per EMT	692
Average POC On-Call Hours per EMR	480

Table 18 – 2021 POC staff statistics.

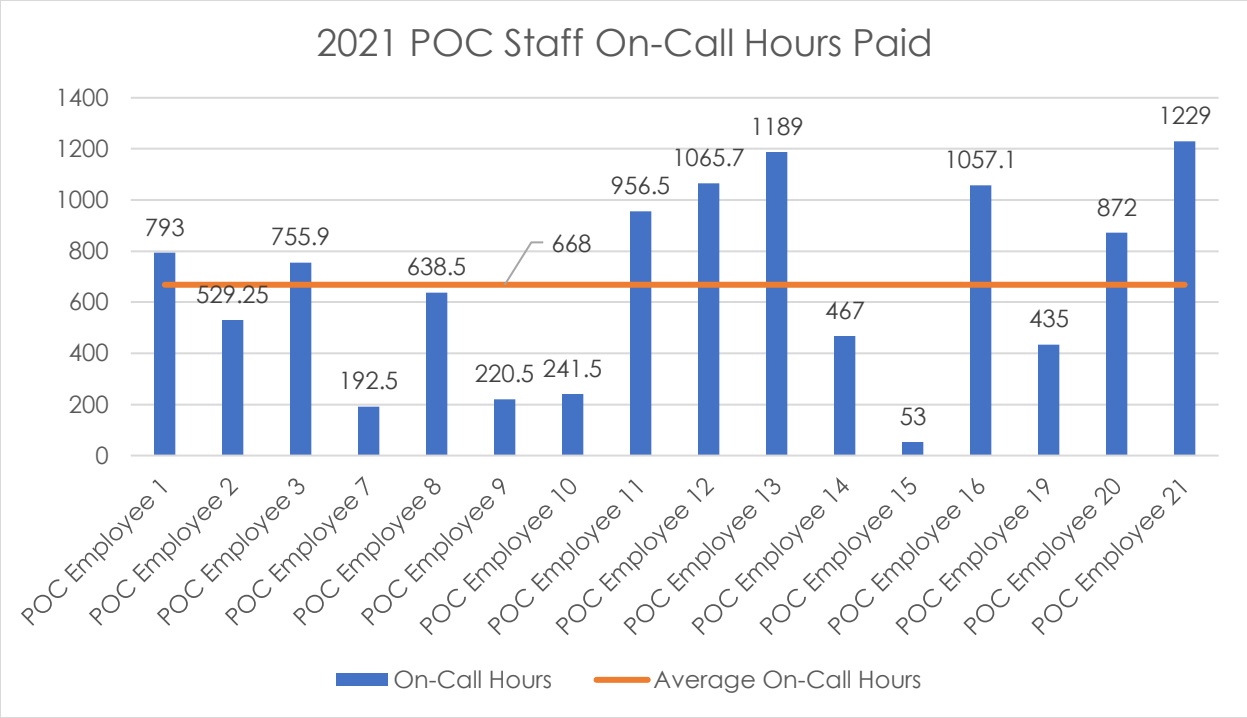

Figure 17 – 2021 On-call staff call time.

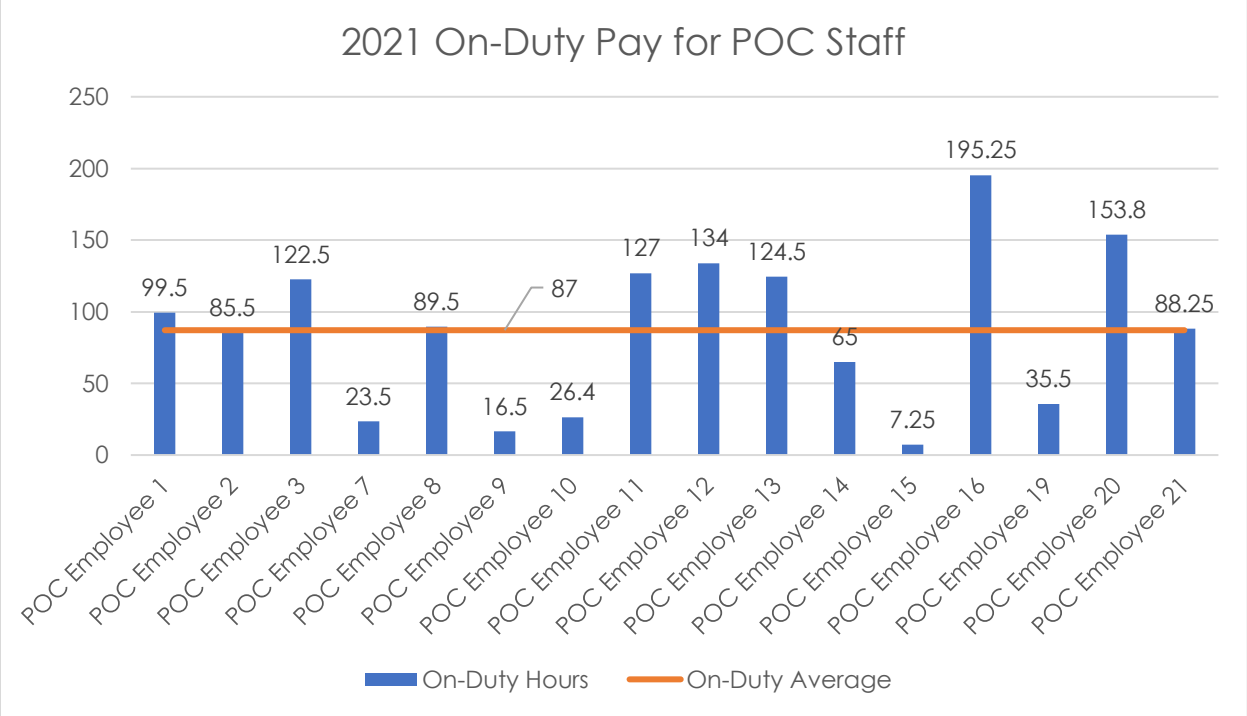

Figure 18 – 2021 On-duty pay for POC staff.

As part of the WAS assessment and staffing exploration, a statistical model is used to explore the relationship between on-call hours and on-duty hours (Figure 19). The more on-call hours a staff member takes the greater number of ambulance runs they should

respond to. This statement has variability primarily due to weekend and night call time, but for this assessment there is a strong correlation. Table 19 shows an additional metric of on-duty and on-call hours by EMS provider certification level.

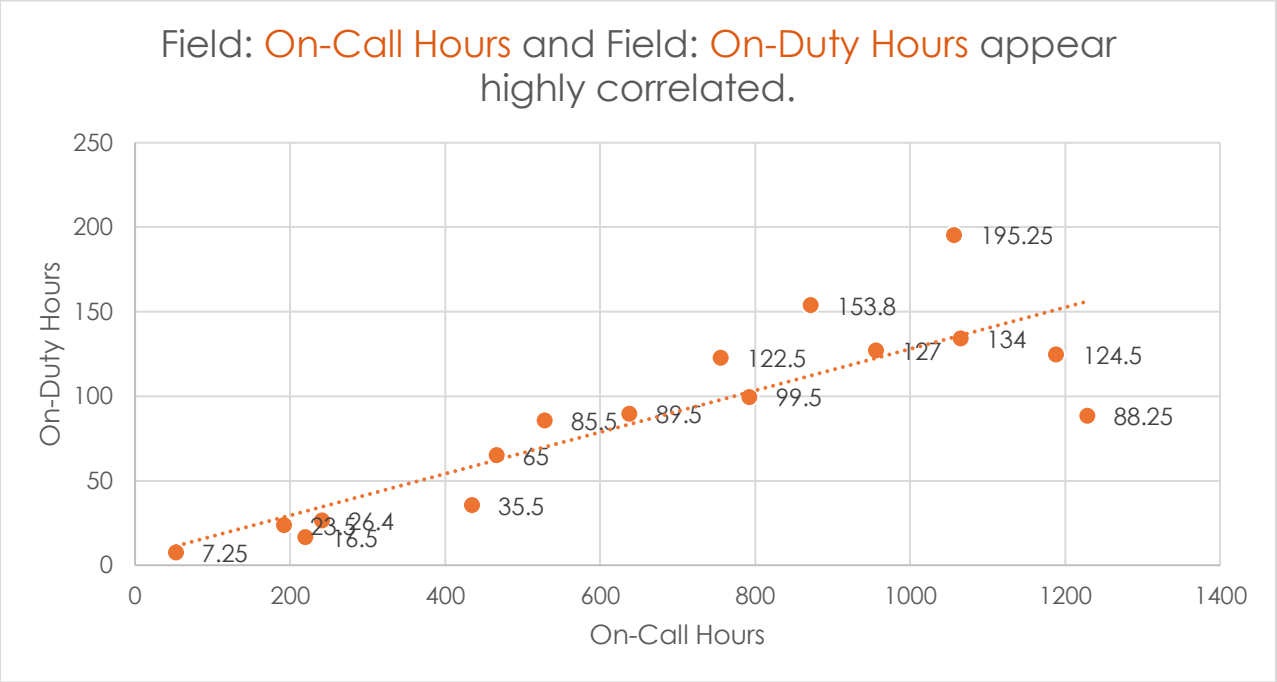

Figure 19 – On-Call and On-Duty hours correlation.

Cert Level	Sum of On-Call Hours	Sum of On-Duty Hours
EMT	8296.7	1117.7
EMR	2398.75	276.25
Grand Total	**10695.45**	**1393.95**

Table 19 – On-Call and On-Duty hours by certification level in 2021.

Staffing Discussion and Considerations

The WAS staffing model is currently providing adequate ambulance coverage to the community. This staffing model's sustainability depends on the ability to continue to utilize POC staff to complement full-time employees. To this end, the considerations below focus on continuing the existing POC staffing model and on additional staff recruitment.

- Ensure a strong culture in which both the POC staff and the full-time employees foster a sense of belonging and engagement
- Consider wage adjustments for POC staff as discussed earlier in this document.
- Continue to prioritize EMT and EMR recruitment and strongly consider hosting an EMR and/or EMT class in Wabasha in the next year or two.
- Ensure recruitment strategies such as high school career fairs and community events are in place and routinely followed.

- Continue and monitor the minimum on-call hours commitment for POC staff. Consider a three-month average for such minimum hours and provide each staff member with a private monthly report of their hours.
- Set annual goals for the number of POC staff as well as a reasonable commitment to taking call time. Doing so will allow for more evenly allocated call-time and reduce the risk. To clarify, the current state

Response time to Life-Threatening Emergencies

Overview

As an ambulance service primarily focused on 911 medical and traumatic emergencies, WAS is obligated to ensure prompt and efficient response to life-threatening emergencies. in cases of high acuity medical or traumatic emergencies, response times do matter. In a cardiac arrest situation, for example, early Cardio-Pulmonary Resuscitation (CPR) and defibrillation save lives (Figure 20). The American Heart Association's position is that brain death and permanent death start to occur in 4–6 minutes after a person experiences a cardiac arrest. In fact, this does not mean that the CPR and defibrillation can only be provided by the ambulance service, but rather the focus should be on such treatment between the time of the witnessed cardiac arrest and the arrival of the ambulance. This pre arrival treatment would include laypersons, law enforcement, or other capable attendees at the patient's side. Unfortunately, and is all too common, cardiac arrests often occur in situations where there is not a nearby AED (Automated External Defibrillator) or capable person to provide CPR. In these cases, the ambulance service is the first treatment a patient will receive, which underscores the importance of immediate and prompt response times.

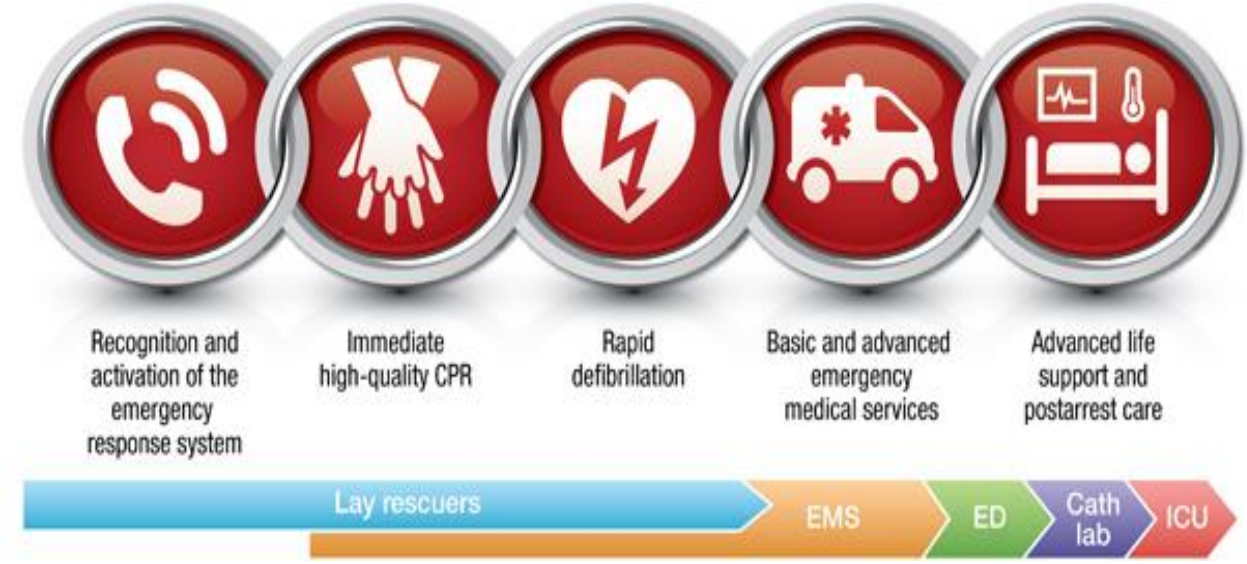

Figure 20 – The American Heart Association algorithm for best possible cardiac arrest outcomes.

While the above scenario focuses on cardiac arrests, there are several other medical and traumatic emergencies in which time is of the essence and a prompt response is directly correlated to a positive patient outcome. However, the percentage of 911 responses where minutes can truly make a difference is in the range of 5% or less.

One of the primary reasons why ambulances use lights and sirens (L&S) is to potentially shorten response times to real or perceived life-threatening illnesses or injuries. When initially responding to a 911 scene, the responding ambulance typically determines whether to use L&S based upon limited information provided by the 911 or other call center. As is the case in Wabasha County, the County provides dispatch services for WAS ambulances. 911 phone calls or text messages are answered by a dispatcher or call-taker and a series of questions asked. Common medical emergency questions include the caller's location information, the nature of the emergency, the age of the potential patient, and the general symptoms. Additional information may be available, but this initial information is limited and is used to dispatch potentially needed resources such as police, fire, and EMS.

Dispatching and Emergency Medical Dispatch

Often, EMS dispatch centers provide what is called Emergency Medical Dispatch (EMD) protocols with trained dispatchers and call-takers. EMD is a formalized and typically computerized call taking process in which the 911 caller is subject to a series of progressive questions. As these questions are answered by the 911 caller, the system algorithm displays lifesaving pre-arrival instructions based upon the specific type of event determined by EMD. These pre-arrival instructions are then provided by the dispatcher to the 911 caller at the scene. For example, in the case of a cardiac arrest, the 911 caller would be offered instructions on how to provide chest compressions and other CPR procedures. Other common examples include lifesaving bleeding control, emergency childbirth, airway obstruction, or aspirin for a patient with chest pain. An additional function EMD provides is to determine the mode of response to a scene for the ambulance service. In other words, based on the EMD call process's outcome, the system will recommend to the responding ambulance the use of lights and sirens. The priority of the response considers the patient acuity and immediate life-threat as determined through the EMD process.

EMD saves lives and should be considered part of the EMS system prior to physical resources being on scene. This is not the case for Wabasha County due to its limited resources for implementing such programs. However, it is common for EMD services to be provided by an outside entity such as a Secondary Public Safety Answering Point or Secondary PSAP. Gundersen Health System out of La Crosse, provides EMD to seven counties in western Wisconsin and southeast Minnesota while Mayo Health System provides similar service to many areas in Minnesota.

Response Time Practices

A best practice for 911 ambulance services is for services to understand the applicability of response times to the communities they serve and be able to measure and improve response time segments as appropriate. There is no shortage of controversy around the EMS industry in terms of the importance of response times, but as stated above there is solid evidence that response times do matter in a small percentage of patients. Further discussion on various response time perspectives is out of scope for this document and not immediately pertinent to this assessment.

EMS and fire departments typically use similar response time metrics and segments to measure and track performance. These metrics historically have been determined by a

few different initiatives or organizations. As an example, the National Fire Protection Agency (NFPA) Standard 1710 provides recommendations for fire-based EMS. Typically, busy urban and suburban EMS markets around The U.S. have set as goals response times based upon either these standards or more appropriately based upon their individual EMS system and the needs of their patients and communities. In settings of rural and lower volume EMS, response times rarely are given the same level of credence and priority as they are in larger EMS markets. It is important to note that regardless of where the emergency occurs, a critical patient in a life-threatening situation, such as a cardiac arrest, will immediate CPR and AED treatment immediately whether they live in Minneapolis or in Wabasha.

Figure 21 below illustrates the most universally used EMS response segments. The call processing time is a measure of dispatch time and typically out of the immediate control of the ambulance service.

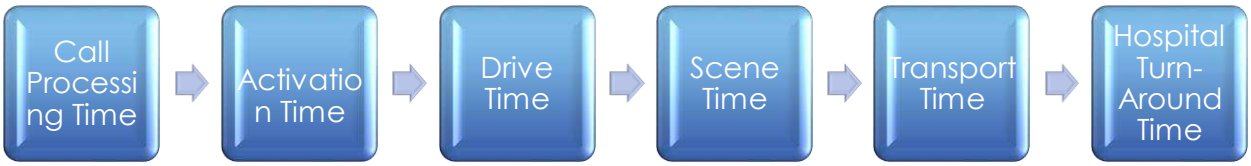

Figure 21 – Typical measurements of response time segments in EMS.

According to the information provided for this assessment in Table 20, approximately 42% of responses to scene were considered emergent with the use of L&S. This is a lower use of lights and sirens than several comparatively sized communities utilizing EMD where the proportion is closer to 60%. It is suspected, however, that the data in WAS is inclusive of all responses and not 911 alone. This would naturally bring down the number of L&S responses proportionally as transfers, special events, and other non-911 responses would be included.

Response Mode to Scene (eResponse.23)	Number of Runs	Percent of Total Runs
Non-Emergent	274	57.32%
Emergent (Immediate Response)	199	41.63%
Emergent Downgraded to Non-Emergent	4	0.84%
Non-Emergent Upgraded to Emergent	1	0.21%

Table 20 – WAS 2022 through December 25th response modes.

Figure 22 provides information for WAS relative to the activation response time segment. Of importance to note is that these times are reported manually by crew members into the data collection patient care report. These activation times are averaged between the paid on-call staff and the full-time on premises staff. The expectation for activation times would be that the on-premises, full-time staff on premises would have a significantly shorter activation time than the on-call crews. This is because the POC staff are coming in from their homes or businesses to the station and then responding in the ambulance to the 911 call. For 911 response with in-house staff, the expectation would be to be enroute

to a call in 60-90 seconds or less. Figure 22 shows the time during the 24-hour periods of 2022 the 911 responses occurred.

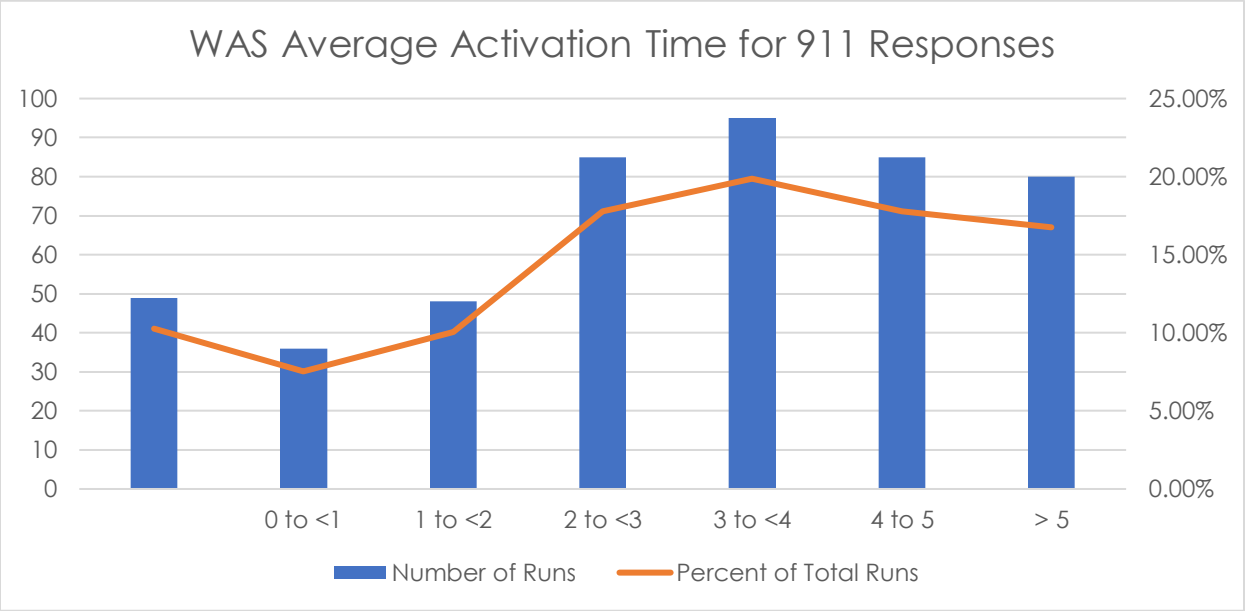

Figure 22 – WAS average 911 response activation times for 2022.

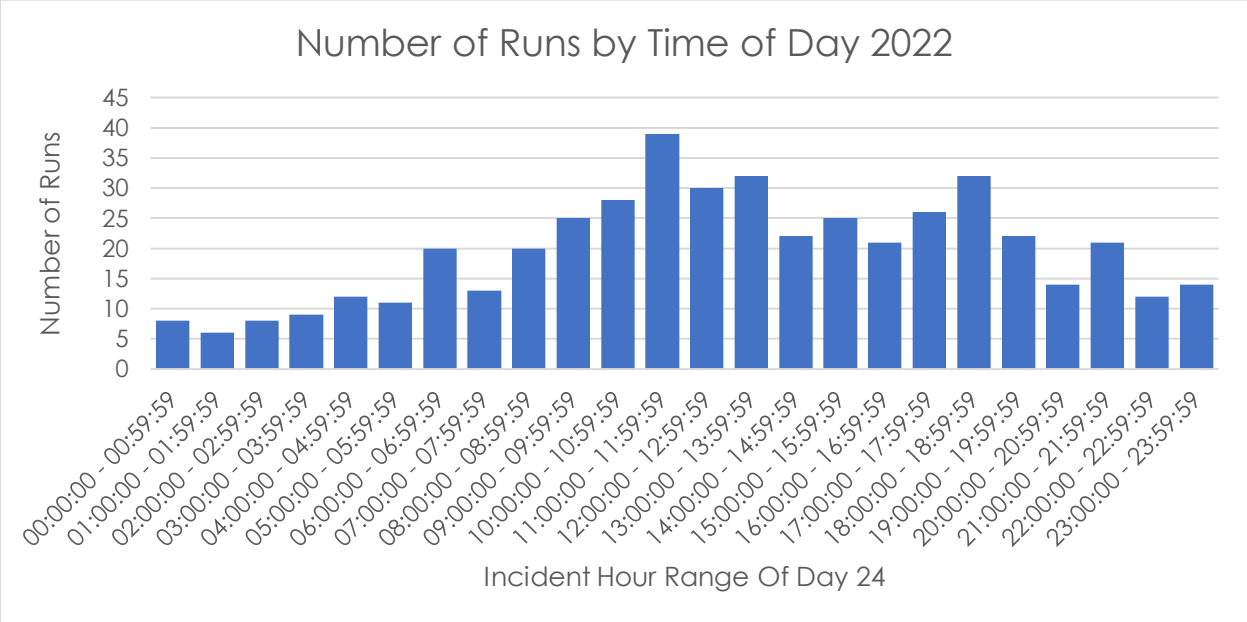

Figure 23 – Runs by hours of day in 2022.

As mentioned above, and when looking at life threatening injuries such as cardiac arrest where brain death can occur in six minutes or less, it is helpful to understand the response radius WAS is able to achieve. Figure 23 below accounts for a 6-minute response where one minute is utilized in call processing and an additional minute is utilized in activation of the ambulance. What remains is a 4-minute drive time radius as illustrated. This is by far

a best-case scenario and considers WAS staff are in house. Since more than half of the staffing time for WHS is utilization of POC staff, where the staff members respond from home to the station and then in the ambulance, it is more than likely that in additional 3-minute activation time would be added, leaving only a 1-minute drive time to be at scene in less than six minutes. Figure 24 illustrates this drastic contrast.

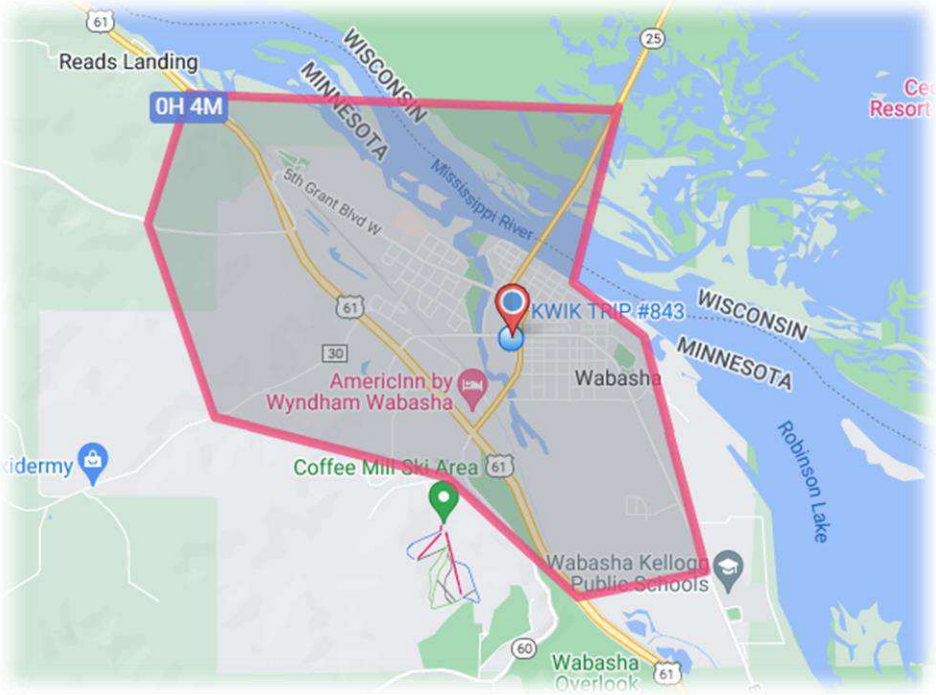

Figure 24 – 4-minute drive time from WAS station.

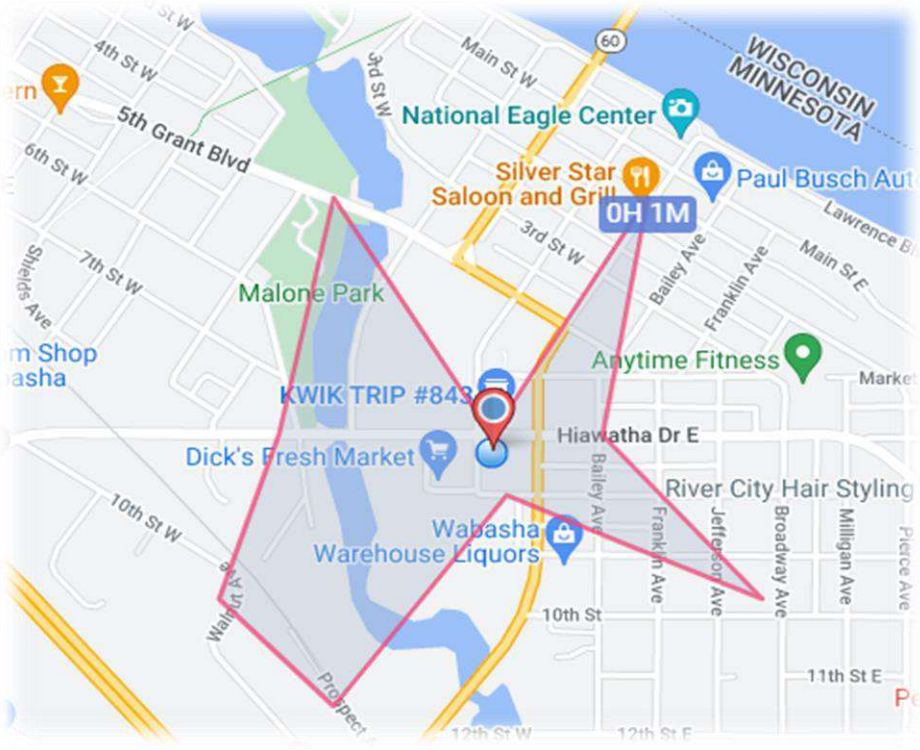

Figure 25 – 1-minute drive time from WAS station.

Response Time Considerations

The WAS staffing model is currently providing adequate ambulance coverage to the community. This staffing model's sustainability depends on the ability to continue to utilize POC staff to complement full-time employees. To this end, the considerations below focus on continuing the existing POC staffing model and on additional staff recruitment.

- Configure reporting to recognize the L&S response percentage for 911 responses. Ensure responses that do not originate from a 911 emergency call are reported differently.
- Set an expectation for full-time staff to be enroute to a 911 response in less than 90 seconds (about one and a half minutes) during the day.
- Ensure that when full-time staff leave the station on duty, that they are in the ambulance and with their partner. Full-time staff should always be with their ambulance and ready to response.
- Work with Wabasha County to increase the 911 dispatch service level to EMD or consider outsourcing the EMD component to a Secondary PSAP.

Service area and potential growth

In the state of Minnesota, ambulance services are assigned primary service areas or PSA. A PSA consists of the geographic territory assigned to that ambulance service and of which that ambulance service is responsible for providing service. Figure 25 below shows a relatively accurate depiction of the WAS PSA.

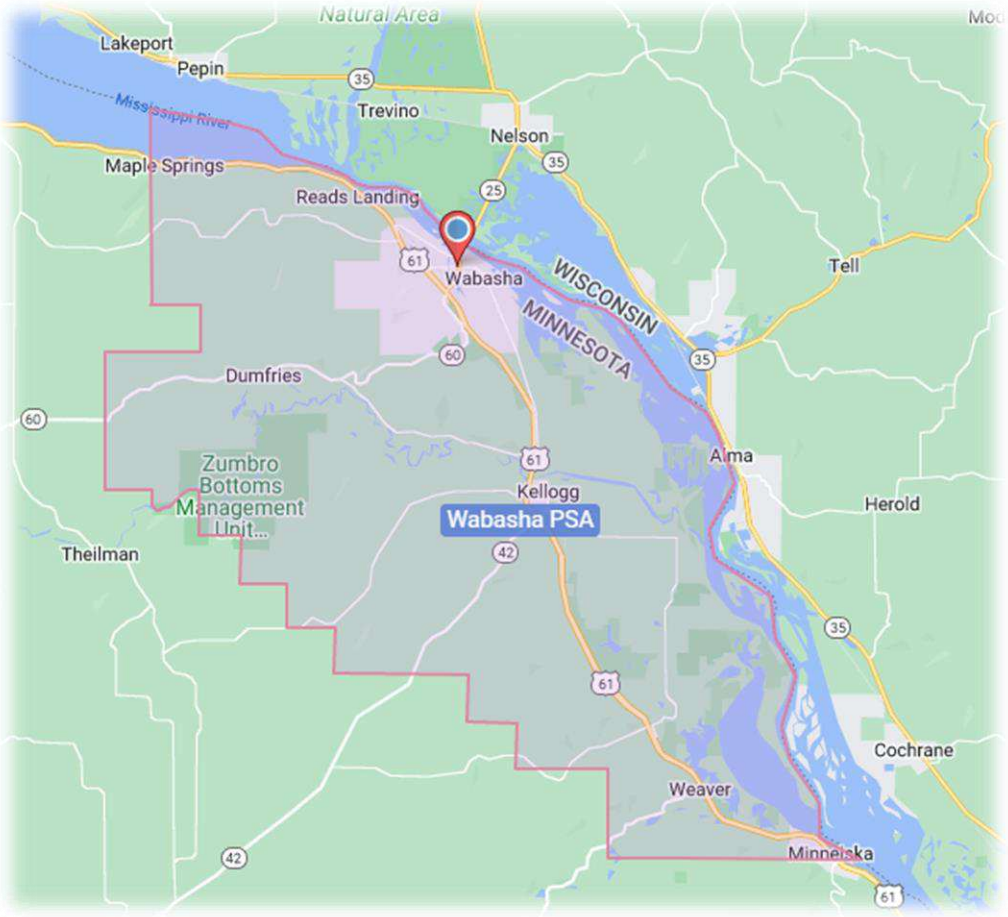

Figure 26 – WAS PSA.

As part of this assessment project, the question was asked of the potential for service area expansion or contraction and the related impact upon WAS upon doing so. In Minnesota, WAS is bordered by Lake City Ambulance to the northwest, Plainview Ambulance to the South, and Winona Area Ambulance to the southeast. Wabasha is about 18 minutes from Lake City, 22 minutes from Plainview, and 34 minutes from Winona. Both Lake City and Plainview ambulance services are stable and operate well with typical challenges related to staffing. It is unlikely that WAS would realize any expansion of PSA in Minnesota.

Being located on the Mississippi River with Wisconsin just a couple of minutes away, there could be potential for additional service area in Wisconsin. Nelson, Wisconsin is three miles from the WAS station and directly across the river. Nelson does not provide ambulance service for its community but rather responds as first responders with the ambulance service out of Pepin Wisconsin providing transport. Pepin, like other small ambulance services, may be open to partnering for WAS to provide backup service at least to the community of Nelson. Presently, WAS would be allowed to respond as mutual aid into Wisconsin without a Wisconsin license up to ten times per year. Any additional responses or if the responses are expected or planned, it would require a state of Wisconsin ambulance operating license.

Expansion/Contraction Considerations

As the state of EMS in rural communities continues to struggle, primarily with procurement of volunteer and paid on call staff, discussions need to occur with other EMS organizations where constructive collaboration could be produced. These discussions often must be handled delicately and always respectfully with common goals and missions and the communities served as the beneficiaries.

- Maintain or generate open lines communication with neighboring ambulance services. This communication will assist profoundly in times of mutual aid and backup services.
- Mutually create guiding documents with nearby Wisconsin EMS services to identify constructive interaction, benefits, and risks of strategic partnerships.
- Ensure that when full-time staff leave the station on duty, that they are in the ambulance and with their partner. Full-time staff should always be with their ambulance and ready to response.
- Meet with a representative of the Wisconsin Department of Health services, EMS division, to learn about the licensure application process and ongoing efforts.

PERSONNEL – RETENTION, ENGAGEMENT, AND RELATIONSHIPS

Overview

When approached by the City of Wabasha about the potential to perform this overall assessment, a fair amount of concern was expressed relating to staffing challenges. Of associated concern was the repetitive turnover of ambulance service directors. WAS has gone through five directors in the past ten years and is on the second director in as many years since discussions around this assessment had started. In addition to the directors' challenges, there is a fair amount of internal strife amongst both the full-time and the POC staff.

In 2021, and before this assessment, the Emergency Medical Services Regulatory Board (EMSRB) of Minnesota administered a survey to existing and former ambulance service staff. The Wabasha Ambulance Sustainability Assessment consisted of sixty-nine questions covering a wide array of topics with the intent of the survey to produce results which can help identify current state and the potential for continued sustainability as a hybrid volunteer service. In addition to the standard yes/no questions, the survey allowed for open commentary from the respondents. Numerous comments were provided, and the writer of this assessment has accessed and has reviewed the remarks. The writer of this document and assessment was present when the survey results were presented to the Wabasha Ambulance Commission. The survey provided by the EMSRB produced a score in which the relative risk of sustainability as a volunteer ambulance service placed Wabasha in the significant risk category. While the survey used was geared for truly volunteer ambulance services, there is merit in the survey's outcome.

As part of this assessment, twenty-four total individuals were interviewed. Included were 20 EMS staff and four administrative or support staff from City Hall. For the EMS staff, two interviewers were utilized who met individually with staff using a standardized set of questions in a SWOT (Strengths, Weaknesses, Opportunities, and Threats analysis format (Appendix A) and results summarized below in Figure 26. Participating in the interviews

with the principal consultant on this project were the mayor, the city administrator, the newly hired and outgoing interim ambulance directors, the finance director for the city, and a human resources representative.

Most of the non-human aspects of the SWOT analysis have been addressed in previous sections of this document. This concluding section will concentrate on personnel, culture, and leadership structure.

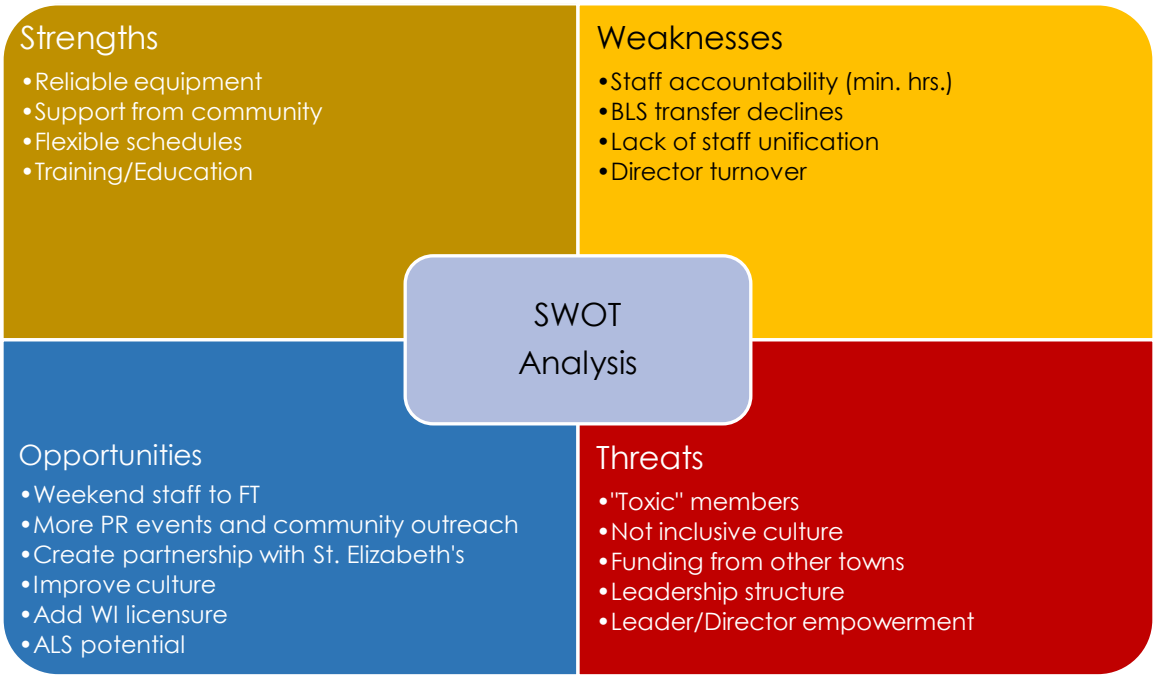

Figure 27 – S.W.O.T. Analysis of WAS

Culture of Current Staff

As is often the case with smaller community-based EMS services, the group of EMS response staff is made up mostly of community members of various ages and backgrounds. As is also common, there are several staff who are related to each other through family and others who grew up in the community together. Aside from these staff, there are a few full-time and POC employees who come from outside of the community. As can be expected, there is some perceived friction between the local staff and those from outside of the area. This issue was also mentioned a few times in the interviews with staff.

Also discovered in both the interviews and the EMSRB survey comments, was the feeling by at least a few staff that there are a few POC staff members who are challenging to work with. There is a notion that these staff members are responsible for other staff turnover, including the director's position.

WAS Culture Improvement Considerations

Workforce culture improvement is a complicated and not easily mitigated issue. There are no simple recommendations which can be offered in this assessment to immediately change the culture.

- Empower the WAS director to be able to have accountability conversations with all staff. The director should notify the City Administrator of the planned conversations and the reasons before meeting with the staff member as a consultancy, courtesy, and forewarning. Any subsequent meetings a staff member may request with the City Administrator should also include the director.
- The WAS director should report directly to the City Administrator and be held accountable for the operating of the ambulance service as other departments in the city are in their respective areas.
- Work with a trained facilitator to bring all full-time and POC staff together to formulate the core values and culture WAS wishes to strive for. This is a process and not something that will change overnight. Once a new culture statement is in place and all crew members agree to abide by it, staff and leaders can use it to create additional accountability for each other.
- Additional interactions and occasional team-building activities between full-time staff and the POC staff. These activities do not need to be complicated but rather focus on increased camaraderie. Crew picnics, dinners, bowling, fun events at routine meetings and training are a few examples.
- City leadership should work with the ambulance director toward moving the ambulance service out of the membership or club mindset, to the employer-employee relationship it is. While POC staff are considered volunteers, and may meet that definition in legal language, they are primarily employees of the City of Wabasha.

Oversight

The City of Wabasha utilizes an ambulance commission which was formed in the mid-1980's to provide guidance and act as a liaison to the City Council and made up of a group of stakeholders who are residents and qualified electors in the City of Wabasha or a township which financially contributes to the ambulance service. The formulation of the commission is below and leaves room for ambiguity due to only three of the five members being defined:

- The mayor shall appoint Ambulance Commission members and confirmed by Cit Council.
- Terms shall be (3) three years.
- Consists of five voting members;
    - One from the medical profession;
    - One Council Member;
    - One current ambulance service member (elected by the Ambulance Service Members);
- The Commission shall be staffed by the current ambulance director, or in their absence, the assistant director, or City Administrator.
- The current ambulance medical director will serve as a liaison member.

The current commission members and their respective roles are;

- Cindy Sheeley (Ambulance Service Member)
- Jayne Dick (community member)
- Monica Walters (Medical professional)

- Tim Wallerich (Council Member, Ward 2, and ambulance service member)
- Tyler Hinrichs (community member)
- Dr. Dennis Spano (Medical Director, Liaison Member)

The following section is taken verbatim from the current City statutes and rules:

The purpose of the commission is to is to "advise the City Council and Ambulance Director regarding the operations of the City's ambulance service." The commission is tasked with the following responsibilities;

1. To make recommendations to the City Council and Ambulance Director with respect to the construction, maintenance, repair and management of the City's ambulance facilities, vehicles and equipment purchases;

2. To make recommendations to the City Council on the purchase of any budgeted items exceeding $5000 or any unbudgeted items of more than $500, in accordance with the City of Wabasha Purchasing Policy or as amended;

3. To advise the City Council and Ambulance Director regarding the operation of the City's ambulance service and facilities;

4. To make recommendations to the City Council and Ambulance Director with respect to rates to be charged for ambulance services;

5. To make recommendations to the City Council and Ambulance Director regarding ambulance service specific policies and operating procedures; and

6. To make recommendations to the City Council and Ambulance director regarding opportunities for mutual aid agreements, regional cooperation, level of service, business, and financial analysis of the service; and

7. Assist or provide input at the request of the City Council and/or Ambulance Director regarding the hiring of Ambulance personnel in accordance with the City's Staff Hiring Policy

8. Review ambulance service quarterly or annual reports on expenditures and revenues and provide recommendations.

9. Ambulance funds. All amounts charged by the city and collected for ambulance services are to be deposited in the ambulance department of the general fund. No indebtedness is to be incurred by the City with respect to the ambulance service except as is necessary and incidental to the carrying on of the ambulance service and has been authorized in advance by the City Council. No alterations, repairs or improvements shall be made to any ambulance service facilities, vehicles, or equipment unless authorized by the City Council.

Oversight Considerations

As noted above, the Ambulance Commission was formed forty years ago. At that time, such commissions and committees were common. In the early years, volunteer ambulance services were treated as more of a membership organization than an actual department of the city. Although the concept of such commissions does continue to exist

and often work well, the structure and membership of the Wabasha Ambulance Commission brings concerns. It is recommended that the City of Wabasha strongly consider restructuring the commission role and its membership.

- It is concerning that there are voting members on the commission who are also employees of the ambulance service. The potential for legal concerns and conflicts of interest is present especially if topics such as staff wages, benefits, and working conditions discussed and voted to move forward to the City Council. The City of Wabasha should strongly consider restructuring this commission.
- An additional concern with ambulance staff being part of the commission is that it disempowers the ambulance director and his or her ability to lead. The very staff the director is responsible for leading participate in decisions which could impact his or her employment and ability to perform the job.
- It seems unnecessary and redundant to have two medical professionals on the commission. Assuming that the medical director and ambulance director are both liaisons and medical professionals, the medical knowledge component should be covered.
- Due to the nature and importance of the relationship between Gundersen St. Elizabeth's Hospital and WAS, it does seem pertinent to include a St. Elizabeth's hospital employee, preferably in a leadership role with the hospital, as a voting member.
- The way the roles and responsibilities are written, seems to give the impression that the commission oversees running the ambulance operations. The City of Wabasha should consider re-writing the duties in numbers 1 through 7 in the numbered section whereas the ambulance director is the one making the recommendations to the ambulance commission.

Key Community Relationship Notes

It was clear in the various interviews conducted as well as speaking with the community members, that WAS is a very much appreciated and respected service in Wabasha. WAS is ingrained in the community and a service crucial to its health.

As a department of the city, WAS participates and is included in frequent city meetings and budgetary planning. Going forward, it is important that WAS has a strong relationship of mutuality with the hospital, the fire department, law enforcement, and city leaders. Considering these relationships, a few items of mention and for consideration below.

- WAS, the Wabasha Fire Department, and the Wabasha Police Department are crucial public safety agencies in the city. These departments should be considered parallel purposes with each having responsibility within its intended function. There should not be a hierarchical component between the departments.
- Gundersen St. Elizabeth's Hospital is an especially important stakeholder within the community and for WAS. The relationship between the hospital and WAS must be open, honest, and collaborative.
- Wabasha, like many other similarly sized communities, has numerous nonprofit and other community focused groups. WAS should be willing to work with these groups

and offer information in the form of guessed speaking, ambulance standbys, or community training.

SUMMARY

It has been a privilege working with the numerous WAS staff and leadership, city leaders and staff. Wabasha is truly a gem of a small town, and its people are friendly and welcoming. The assessment team was impressed with the community minded spirit and the desire to keep WAS sustainable and in the community. The City of Wabasha leaders over the years, and most recently, have had the foresight and desire to continue to sustain an ambulance service. City leaders have and continue to give their attention, adequate funding, and now the investment of this assessment to the ambulance service.

All components of a successful and sustainable small town, rural ambulance service, are in place. The financial and operational change considerations within this document are straightforward and can be implemented quickly. The challenge which continued to resonate throughout this assessment is that of a few paid-on-call staff strong personalities and power struggles. As important as it is to have strong and competent leaders, it is equally important to have competent, collaborative, and engaged followers who are willing to be constructive and respectful to each other. In volunteer and paid on call settings, such as WAS, it is common for an occasional staff member to equate their value to the ambulance service with the number of on-call hours they pick up, excusing them from unacceptable behavior. Going forward, WAS must treat all staff equally and hold all staff accountable for their actions regardless of their perceived value to the service. "The whole is greater than the sum of its parts." – Aristotle.

It has been a pleasure to conduct this assessment, and we wish the City of Wabasha and its ambulance service the best, and we know the service is well cared for with supportive city leadership and a new capable director.

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Appendix A
S.W.O.T. Interview Questions

Name: _____ Interviewer: _____

General info about interviewee:

Strengths

- What do you like most about working here?
- What are things your company does well
- What do your customers say you do well?
- Explain the company culture and work environment.
- Other comments:

Weaknesses

- What parts of working here are the most challenging?
- Is there anything that frustrates you here?
- What are your resource limitations?
- Where do you see areas that need improvement, and how would you improve them?
- Is there something in the organization culture that is hindering its success or growth?
- Other comments:

Opportunities

- What would make your experience at work better for you?
- Is there anything else that you would like to learn here but are not?
- What areas do you see as an opportunity for growth? (Education/training, staffing, leadership…)
- Other comments:

Threats

- When was the last time you thought about leaving our team? What prompted it?
- Follow up to the above question: What is the single most meaningful action the company could take to address this issue?
- Any industry or economic trends hindering you?
- How does the company respond to innovative technologies or best practices?
- How do the company & employees respond to change?
- Other comments?

Appendix B
S.W.O.T. Interview Questions

Addition 7C

Creating an Ambulance Commission

7C.01 Establishment

An Ambulance Commission for the City of Wabasha is hereby created, to be composed of five (5) voting members, one of which shall be from the medical profession, one shall be a Council Member, one shall be a current Ambulance Service member. The Ambulance Service member shall be elected by the Ambulance Service Members. The term of office of each commission member shall be three (3) years, except that the first commission members shall be appointed for terms expiring the third Tuesday of April of the years 1985, 1986 and 1987, respectively. Thereafter the term shall be three (3) years each. The Mayor shall appoint the Ambulance Commission members, confirmed by a majority vote of the City Council. The Ambulance Commission shall be staffed by the current Ambulance Director or in their absence, the Assistant Ambulance Director, or the City Administrator.

The current Medical Director for the Ambulance Service or designee will serve as a liaison member of the Ambulance Commission.

7C.02 Qualifications and Duties

All Ambulance Commission members shall be residents and qualified electors of the City of Wabasha or qualified electors of townships in the Wabasha Ambulance Service Area whose townships financially contribute to the Wabasha Ambulance Service. One Commission member shall be a medical professional (MD, DO, DC, RN, LPN, Paramedic, EMT). One Commission member shall be a City of Wabasha Council Member.

7C.03 Vacancies

In case the office of any member shall become vacant during the member's term, the Mayor shall appoint a person of like qualifications, confirmed by a majority vote of the City Council, as soon as practical thereafter, to fill such vacancy during such unexpired term.

7C.04 Quorum

A majority of 3 members constitutes a quorum for the conduct of business of the Ambulance Commission.

7C.05 Powers, Duties and Responsibilities

The Ambulance Commission is to advise the City Council and Ambulance Director regarding the operations of the City's ambulance service. The Ambulance Commission shall have the following responsibilities:

1. To make recommendations to the City Council and Ambulance Director with respect to the construction, maintenance, repair and management of the City's ambulance facilities, vehicles and equipment purchases;
2. To make recommendations to the City Council on the purchase of any budgeted items exceeding $5000 or any unbudgeted items of more than $500, in accordance with the City of Wabasha

Purchasing Policy or as amended;
3. To advise the City Council and Ambulance Director regarding the operation of the City's ambulance service and facilities;
4. To make recommendations to the City Council and Ambulance Director with respect to rates to be charged for ambulance services;
5. To make recommendations to the City Council and Ambulance Director regarding ambulance service specific policies and operating procedures; and
6. To make recommendations to the City Council and Ambulance director regarding opportunities for mutual aid agreements, regional cooperation, level of service, business, and financial analysis of the service; and
7. Assist or provide input at the request of the City Council and/or Ambulance Director regarding the hiring of Ambulance personnel in accordance with the City's Staff Hiring Policy
8. Review ambulance service quarterly or annual reports on expenditures and revenues and provide recommendations.
9. Ambulance funds. All amounts charged by the City and collected for ambulance services are to be deposited in the ambulance department of the general fund. No indebtedness is to be incurred by the City with respect to the ambulance service except as is necessary and incidental to the carrying on of the ambulance service and has been authorized in advance by the City Council. No alterations, repairs or improvements shall be made to any ambulance service facilities, vehicles, or equipment unless authorized by the City Council.

7C.06 Meetings

Regular meetings will be established **at least monthly** for the Ambulance Commission and Commission members shall have a duty and obligation to regularly attend meetings and be prepared for discussion.

7C.07 Retention of Powers

The City of Wabasha shall have, maintain and retain title to the property, including real estate and personal property used for, incident of or in connection with the Ambulance Commission and shall retain unto itself the obligation, power, and authority to establish, enforce, order, codify, amend and repeal all ordinances, rules, and regulations for the governing of the Ambulance Commission, whether herein created and established or otherwise defined.

7C.08 Personnel

The City of Wabasha hiring policy will govern the hiring, compensation, and retention of all Ambulance Service Personnel.
The Ambulance Director shall be responsible for day-to-day operations of the service. The Ambulance Director reports directly to the City Administrator. All grievances against personnel will be handled in accordance with the City of Wabasha Employment policies.

Appendix C
ROI Transfer Example

Transfer Profitability Formula – Medicare BLS Non-Emergency to La Crosse

(First crew takes the transfer and are backfilled by EMTs at activation wages)

- **Revenue = (Medicare Base Rate Allowable) + (Loaded Miles*Mileage Allowable)**
  - = $277.14 + ($63.8 * $8.80)
  - = $277.14 + $561.44
  - **= $838.58**
- **Overall Expense = Labor Costs (backfill 911) + Fuel Cost + Supplies Cost + Vehicle Usage Cost + Misc. Costs**
  - **(See below) = $93.60 + $64.00 + $34.13 + $110 + $45.00**
  - **= $346.73**
- **Profit/(Loss) = Revenue – Expense**
  - **$491.85 for 2023**

Assumptions

- The first crew is on duty crew and goes on the transfer. The full-time daytime crew labor expense is not an incremental (direct) cost of performing a transfer during this shift.
- The second crew is an on-call crew activated to on-duty pay from home until the transfer ambulance is back to town.
- Gundersen St. Elizabeth's (GSTE) > Gundersen Lutheran Medical Center (GLMC) La Crosse
- FFS - Fee-for-service (straight) Medicare patient. Advantage plans may pay more than FFS but not less. Medicaid is a few dollars less. Commercial is much more.
- BLS base rate…the lowest reimbursed transport base rate. The reimbursable amount is highlighted below.
- 63.8 loaded miles.
- 128 miles round trip.

Medicare 2023 reimbursement rates.

2023 Reimbursement Schedule and WAS Rates	HCPCS	Medicare (Rural)	MN Medicaid	WAS 2022 Rates
Medicare/Medicaid Reimbursement	**HCPCS**	**Medicare**	**MN Medicaid**	**WAS 2022 Rates**
BLS and ALS Mileage	A0425	$8.80	$ 8.47	$ 21.00
ALS Non-Emergency	A0426	$332.57	$ 318.52	$ 1,080.00
ALS1 Emergency	A0427	$526.57	$ 430.03	$ 1,710.00
BLS Non-Emergency	A0428	$277.14	$ 265.41	$ 900.00
BLS Emergency	A0429	$443.43	$ 430.03	$ 1,440.00
ALS 2	A0433	$762.15	$ 730.12	$ 2,475.00
SCT	A0434	$900.72	$ 862.86	No Set Rate

Time to complete transfer > start (dispatch) to finish: 3 hours

Dispatch to Arrival at GSTE	0:07
At Hospital - GSTE	0:18
Drive Time GTSE to GLMC	1:07
Time at GLMC	0:20
Drive Time Back to Wabasha	1:08
Total Paid Time on Transfer	3:00

Labor Costs

- Labor cost for example: $36.00 * 3 hours = $93.60

Second Crew - Backfill Labor Costs while Transfer is Out					
Provider Level		Wage	Benefits and Taxes		Total
EMT 1 Activation	$	15.00	20%	$	18.00
EMT 2 Activation	$	15.00	20%	$	18.00
			Labor Cost per Ambulance Hour	**$**	**36.00**

Ambulance Value Cost

Ambulance wear & tear (per transfer) = $110. This number is conservatively high but assumes the transfer reduces the market value of the ambulance by this amount. = $110.00

Ambulance and Equipment Cost	Transfer Only Life Span (Yrs)	Annual	Life of Amb Total Miles	Average Ambulance Life Use per Transfer	Annual Trips	Portion of Ambulance for IFT	Cost per Trip
$ 220,000.00	10.0	$22,000.00	180000	0.06%	60	0.3	$ 110.00

Transfer direct operating costs

Ambulance Use and Supplies				
Fuel Cost				
Fuel cost per gallon	$	4.00		
Round Trip Miles	$	128.00		
Ambulance Mileage (MPG)		8		
Total cost of Fuel	$	64.00	Formula: (128/8)*$4.00	
Vehicle Usage Costs				
Maintenance/Usage per Mile	$	0.17	Assumes $500 maintenance every 3,000 miles	
Other - per mile	$	0.10		
Total cost of Fuel	$	34.13	Formula: ($1.50+$0.50)*128 miles	
Supplies Cost				
Nasal Cannual	$	4.00		
Oxygen @4LPM	$	7.00		
ECG Patches	$	4.00		
Billing Charge	$	30.00		
Total cost of Fuel	$	45.00		

Appendix D

Glossary - Ambulance Service General Terminology

This document contains a variety of healthcare related financial and non-financial terms and phrases. The most used wording and phrases are below:

Account – When a person (patient) utilizes an ambulance, an account is created for billing and medical report keeping.

Accrual Accounting – Accounting method which assumes payments are expected or money due.

Adjustment – A billing adjustment is made for a variety of reasons and is typically a reduction in the amount billed.

Advance Beneficiary Notice (ABN) – This is a document the ambulance staff will give a patient in a non–emergency transport situation where it is unknown if insurance or a government payer will cover the trip's cost. This form is signed by the patient or patient guarantor stating they will pay the cost of the ambulance trip if no other payer does.

ALS - Advanced Life Support Services. Typically, the provision of advanced life support is through at least one paramedic on the ambulance and that paramedic using advanced patient assessment and/or procedures. An example of ALS would be a paramedic starting an IV on a patient. For Medicare purposes, Emergency Medical Technicians licensed or certified at the Intermediate level can also provide assessments and procedures in which ALS billing charges may be used. For billing purposes, there are a variety of ALS levels and response modes which can be billed. Billing charges are explained later in this document.

Ambulance – The State of MN regulates ambulance services and specifies the requirements for an ambulance to be able to legally operate in the State. To bill federal payers (such as Medicare), an ambulance must meet or exceed State requirements for both equipment and licensed provider staffing.

Appeal - A process in which because an ambulance claim was rejected by the payer, subsequent attempts are made to collect the owed amount.

-B-

Bad Debt – Debt or money owed to the ambulance service from the provision of services which is unlikely to be paid. Typically refers to the sum of balances across multiple accounts. Bad debt is typically due to a patient unable or unwilling to pay their portion of an ambulance bill.

Beneficiary – The person(s) covered by insurance.

Benefit - The amount of coverage a payer provides to its beneficiary.

Billed Amount – The total amount billed to the patient or the patient's payer.

BLS - Basic Life Support. The level at which a basic EMT crew can provide patient care. Typically, BLS ambulance crews can provide limited medications and procedures.

-C-

Cash Accounting – Payments and expenses are recorded in the period they are received.

Claim Number – The unique number used by payers to identify the ambulance trip and related charges.

Claim Status – The current state of a claim as it processed through a payer and the ambulance revenue cycle course.

Collections – When an account is delinquent and multiple attempts have been made to collect the past due amount from the patient, the account is moved to the "collections" phase where it is handed off to a licensed collection agency.

Collection Agency: A third party licensed agency able to use additional procedures and tactics to collect a debt. Primarily, a collection agency can impact an individual's credit rating and credit report.

Complete: When a claim has been completed settled and the agreed upon payment has been received by the ambulance service

Co-insurance - The cost share portion of a bill which the payer expects the patient to be responsible for. An example is an insurance plan with a 20% co-insurance requires the patient to be responsible for $200 of an $1,000 ambulance bill if the patient's deductible has not been met.

Contractual Allowance –The portion of an ambulance bill in which the ambulance service is not allowed to collect. With a government payer such as Medicare or Medicaid, the ambulance service must legally accept their payment amount in full and is not allowed to bill the patient for the remainder. For example, Medicare may pay $400 of a $1,000 ambulance bill and the remaining $600 would be considered the contractual allowance and be "written-off" as uncollectable. Contractual allowances can also apply to private insurance companies or other entities in which the ambulance service is in a contractual agreement for a discounted rate.

Co-Pay – Different from "Co-insurance," a co-pay is an actual flat fee which the payer expects the patient to be responsible for regardless of whether the patient's deductible has been met. It is common amongst both government and private payers to expect a co-pay when utilizing an ambulance or emergency department. Typical co-pay amounts range from $50 to $200.

Contracting - Refers to a participating or network clinician.

Coordination of Benefits (COB) - A way to decide which insurance company is responsible for payment if you have more than one insurance plan.

Contractual Adjustment - A part of your bill that your Ambulance Provider must write off (not charge you) because of billing agreements with your insurance company.

Co-payment - A type of cost sharing whereby the insured person pays a specified flat amount per unit of service or unit of time (e.g., $10 per visit, $25 per inpatient hospital day), with the insurer paying the balance.

CPT codes - A coding system used to describe what treatment or services were given to you by your doctor.

-D-

Date of Service (DOS) - The date(s) when you were treated.

Days to bill – The measurement form the date of service until the bill or invoice is sent.

Deductible - The amount you must pay for medical services before your insurance company begins to pay.

Deductible - Family The amount of an eligible expense a covered family must pay annually before the plan will make payment for eligible benefits.

Deductible - Individual The amount of an eligible expense a member must pay annually before the plan will make payment for eligible benefits.

Diagnosis Code - A code used for billing that describes your illness.

DOA - Dead on arrival.

DOB - Date of birth.

DOS - Date of service.

-E-

ER - Emergency Room

EMS - Emergency Medical Services.

EMT – Emergency Medical Technician

Explanation of Benefits (EOB) - The notice the patient and ambulance service receive from an insurance company after obtaining medical services from a doctor or hospital. It outlines what was billed, the payment amount approved by insurance, the amount paid, and what the patient must pay.

-G-

Gross Revenue – The overall charges in a period.

Guarantor – Person or entity who has agreed to take fiscal responsibility for a bill.

-H-

HCPCS - Healthcare Common Procedure Coding System. There are between 40 and 50 of these codes related to all types of ambulance service billing levels. Typically, less than 10 codes are used.

HIPAA - Health Insurance Portability and Accountability Act. This federal act sets standards for protecting the privacy of health information.

-I-

ICD10 - The insurance industry name for a commonly used reference, International Classification of Diseases, 10th Edition. This is a listing of diagnosis or identifying codes used to report the condition of patients who have received healthcare services. This is the standard used by healthcare clinicians and payers throughout the United States.

In Process indicates that the claim is currently being processed.

In Network - Services received within the authorized service area from a participating clinician.

Inpatient - Describes services for individuals admitted to a hospital as registered patients and received hospital care for at least 24 hours.

Inpatient Hospital - The service location for individuals admitted to a hospital as registered patients and received hospital care for at least 24 hours.

Insured - The person who carries the insurance with, also called the employee or subscriber.

-L-

License - An official permit issued by a state to an individual authorizing them to perform health care services.

-M-

Managed Care Plans - A insurance plan that requires patients to see doctors and hospitals that have a contract with the managed care company, except in the case of medical emergencies or urgently needed care if you are out of the plan's service area.

Medical Record Number - The number assigned by your Ambulance Provider that

identifies your individual medical record.

Medicare Advantage Plan: Individuals using Medicare may choose to work with a private insurer who partners with Medicare to offer varying coverage and benefits. In the case of ambulance reimbursement, the advantage plans may have deductible and co-pay amounts different than that of the traditional Medicare plan. Advantage plans are still covered by Medicare allowable amounts and combined payments will not exceed these.

Medicare Assignment - Ambulance Providers who have accepted Medicare patients and agreed not to charge them more than Medicare has approved.

Medicare Part A - Usually referred to as Hospital insurance, it helps pay for inpatient care in hospitals and hospices, as well as some skilled nursing costs.

Medicare Part B - Helps pay for doctor services, outpatient care and other medical services not paid for by Medicare Part A.

Medicare Part C – Often Medicare Advantage Plans use Part C money.

Medicare Medical Savings Account - A Medicare health plan option made up of two parts. One part is a Medicare MSA Health Policy with a high deductible. The other part is a special savings account, called a Medicare MSA.

Member - Any person covered by an insurance policy.

Member Responsibility - The total dollar amount owed by the member or party responsible for this service. This will include any copay, billed amounts over the UCR, charges for non-covered services or other disallowed amounts applied to this service.

-N-

Net Revenue – Gross charges (total amount billed in a period) minus contractual allowances and expected write-offs.

No Coverage - Unable to find benefits. Patient may not have the specified coverage, or their benefits are being set up.

Non-Covered Charges - Charges for medical services denied or excluded by insurance. Patient may be billed for these charges.

Non-Participating Provider - A doctor, hospital or other healthcare provider that is not part of an insurance plan's doctor or hospital network.

NPI (National Provider Indicator) - A 10-digit number used to identify covered providers on all HIPAA covered transactions.

-O-

OIG - Office of the inspector general.

Original Medicare Plan - The traditional pay-per-visit arrangement that covers Part A and Part B services.

Out-of-Network Provider - A doctor or other healthcare provider who is not part of an insurance plan's doctor or hospital network. Same as non-participating provider. Outpatient - Describes services for individuals who receive healthcare services at a hospital clinic or outpatient department but are not admitted as registered patients.

-P-

Paid Amount - The amount has paid for a particular healthcare service.

Participating Provider - A doctor or hospital that agrees to accept your insurance payment for covered services as payment in full, minus your deductibles, co-pays, and coinsurance amounts.

Patient - The person who received mental healthcare services.

Patient Type - A way to classify patients - outpatient, inpatient, etc.

Payer – The person or entity responsible for a charge. Common payers include Medicare, Medicaid, an insurance company, or the patient themselves without insurance. The most typical scenario is when the billable service has a primary payer such as Medicare, Medicaid, or insurance and a secondary payer such as the patient's responsibility for a co-pay or a deductible.

PCR - Patient care report.

PCS - Physician certification statement. Required for non-emergent Medicare transports.

Point of Service Plan (POS) - An insurance plan that allows you to choose doctors and hospitals without having to first get a referral from your primary care doctor.

Primary Insurance Company - The insurance company responsible for paying your claim first. If you have another insurance company, it is referred to as the Secondary Insurance Company.

Private Fee-for-Service Plan - A private insurance plan that accepts Medicare beneficiaries.

Procedure Code (CPT) – Current Procedural Terminology - A code given to medical and surgical procedures and treatments.

Provider – An individual licensed to provide healthcare services.

Pending: indicates that the claim has been entered into the system but is pending review or check write.

-R-

Referral - Permission from your primary care doctor to see a certain specialist or receive certain services.

Responsible Party - The person(s) responsible for paying your hospital bill--usually referred to as the guarantor.

-S-

Secondary Insurance - Extra insurance that may pay some charges not paid by your primary insurance company. Whether payment is made depends on your insurance benefits, your coverage, and your benefit coordination.

Skilled Nursing Facility (SNF) - An inpatient facility in which patients who do not need acute care are given nursing care or other therapy.

Subscriber - The primary person who carries the insurance.

Supplemental Insurance Policy - An additional insurance company that handles claims for deductibles and coinsurance reimbursement. Many private insurance companies sell Medicare Supplemental Insurance.

-T-

Third Party Billing - Submission of an ambulance bill to your primary / secondary insurance carriers on your behalf for reimbursement of ambulance expenses to the patient or to CHFD-EMS. This procedure applies to members and non-members. Members have no out of pocket expenses after payment by the insurance carrier[s]. Non-members are individually responsible for any unpaid balances.

-U-

UCR - Short for Usual, Customary and Reasonable, UCR is a set of commonly billed rates for standard services in specific geographic regions. Based on zip code areas, UCR rates are reviewed on April 1 and October 1 of each year. uses UCR rates to establish the covered amount for services received by clinicians not in the network. As a rule, billed amounts over the UCR rate will be the member's responsibility.

Urgently Need Care - Unexpected illness or injury that needs immediate medical attention but is not life threatening.

Utilization Review (UR) - Hospital staff who work with doctors to determine whether you can get care at a lower cost or as an outpatient.

Write-Off – The amount which is legally allowed to attempt collection on but unable to. This amount typically is sent to a collection agency.