Erin Jenssens

The chief of Portland Fire & Rescue talks about the changing role the bureau is playing in the city's well-being

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The word "firefighter" often conjures up images of burly men clad in heat-resistant suits and iconic firefighter hats, wielding axes and pulling people from burning houses and kittens from trees. But in recent decades, fire departments, particularly in urban areas, have taken on additional duties. Now, responders at Portland Fire & Rescue (PF&R) have taken on some responsibilities resembling those of medical professionals and social workers. Responders are the first to show up when people are having the worst days of their lives, and are routinely confronted with a stark picture of poverty as they aid people who've fallen through the social safety net.

Recently, PF&R launched a program that sends an SUV out to lower-level calls that probably don't require a hulking fire truck or fire engine (there is a difference). A recent study has found that the program could help the PF&R budget-wise, requiring less maintenance and has while freeing up crews and larger vehicles for bigger calls.

Street Roots sat down with Fire Chief Erin Janssens to talk about the changing role of PF&R as it increasingly becomes a primary health care provider to the streets.

Jake Thomas: *A new study came out on the bureau's use of SUVs to respond to lower-level non-emergency calls. I was hoping you could comment on that.*

Erin Janssens: The rapid response vehicles are staffed by two people. They are an SUV that responds to lower-acuity calls. It could be checking on someone's smoke alarm.

What a lot of people don't understand is that 30 years ago, fire departments nationwide worked to create efficiencies to the taxpayers by responding to medical calls in addition to being a fire and rescue resource. We're already responding to motor vehicle accidents and any kind of traumatic injury. We already have medical training, so the role of the fire and rescue emergency services really expanded into medical calls. About 70 percent of our calls are medical calls.

J.T.: *You're a veteran of the bureau. When did the "rescue" part of Portland Fire & Rescue become so integral, because most people just think about the fire side?*

E.J.: When I came in to Portland Fire & Rescue, going on 26 years now, we were called Portland Fire Bureau. Our name was changed to Portland Fire Rescue and Emergency Services. That changed in the early to mid-90s. After that we kind of re-branded ourselves. A lot of people continue to call us "Portland Fire Bureau." Fire is a big part of what we do, we are the provider of fire prevention and suppression services, but we are also doing a lot.

In 1985, Portland Fire then extended from giving the firefighters training in first aid to EMT basic certification and EMT paramedics. We had, and we still strive to have, a paramedic on every fire engine.

J.T.: *What sort of emergencies do first responders have to deal with?*

E.J.: Any type of fire call. All firefighters want to help people; that's the big driver inside them. So when you go on a fire call, they take a lot of pride in using a lot of specialized skill and performing difficult tasks, but it's also very sad. You see a lot of really difficult things as a firefighter, and I think people equate that with police officers. All of these calls that police are going on, firefighters are going on because we're the medical help. Firefighters see people lose their homes and special mementos they have, like a family photo album.

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You also see people lose their lives from fires. You see people die from careless smoking or being under the influence of something. Some that seem really tragic. They're all tragic. One woman's house caught on fire and she got out of the house and realized that the ashes of her sister were in an urn, and she went back in to get the urn and never got out.

We go on all type of medical calls. When (the influenza strain) h1n1 was going around, we ended up going on those calls and making assessments. We go on rescue calls, like the woman who was stuck between the walls. We end up pulling quite a few people out of the river, and I think people forget that that requires resources and specialized response in order to protect people. Hopefully, they're recreating, but other people jump off bridges. We see shootings, stabbings; you name it, we go on it. People struck by cars or bicycle accidents.

Generally, whenever we show up, it's a tragic event and it's the worst day of somebody's life, and we're showing up because they are in a bad way and they need our resources. We take great satisfaction in that and that's a great honor for all of our members, knowing that people trust you enough to call 911.

J.T.: *What are responders' role in the health care of people living on the street. What kind of services can they provide to someone who is having a medical emergency and is homeless?*

E.J.: We have a huge role in that, and we really are the first responders when someone needs help. I think sometimes people forget that we are and have been a big part of that safety net for people who are homeless. I hope to continue providing as much support as we possibly can. So when 911 is activated, we are dispatched. We will do a triage and a patient assessment to see what kind of needs they have. If there seems to be a mental health crisis or something, we'll get police to help with that because with the new behavioral health resources and connections we have we'll try to get them hooked up with those services.

But if someone is calling repeatedly, we can identify if there is a problem and how we can help with the root causes. Do they have mental health issues? Do they not have a heath provider? This is changing dramatically. In the past, 25 percent of the people we responded to generally were uninsured. Hopefully, people will sign up and get some kind of coverage.

We're working on this pilot for the Rapid Response Vehicle program where we will try to do an alternate destination and an alternate transportation pilot. People who don't have any health care, they wait and wait and wait until it becomes a crisis and they're transported by an ambulance – the most expensive way to be transported to the hospital, and the emergency room is the most expensive type of care. So what we're trying to look at is how to reduce health care costs by connecting with the clinic to see if the patient is willing to participate and be transported to the clinic with their provider.

If they don't have a provider, let's get them signed up with some sort of health care coverage and get them into a system where they can get routine care and a complete diagnosis, instead of a Band-Aid approach where it is so intermittent that it just becomes a cycle. Maybe they need wound care but they don't go back because they can't afford a doctor, and then they get an infection and they get really sick and they call 911 and are sent back. So we're now trying to resolve matters in a more proactive and less costly way, and I think the RRVs will help with that. But system-wide, we can look at the solution. And we work closely with Multnomah County Emergency Medical Services. They actually have a social worker. So when someone has been in the system more frequently, we can work with the social worker. Good health is the most primary thing we need to help people attain because if you don't have good health, achieving anything else is going to be really difficult.

J.T.: *Do you have regulars?*

E.J.: Occasionally we do, and we really try to work with the social workers to find good people to help with mental health issues. Hopefully, at least we can get people into shelters or off the street.

J.T.: *Under the Affordable Care Act, we've seen a big expansion of Medicaid. It seems like that could really help get people some stable care. Have you seen any changes to far?*

E.J.: Not yet. It's really early. I'm excited to see the improvements of having more people covered. That'll be a good thing.