



**City of Ashland  
Cost Review Ad Hoc Committee  
Ambulance Service Questions – Ashland Fire & Rescue  
Prepared by Chief Shepherd**

A little background before answering the first couple of questions.

It is important to point out the ambulance service is not entirely separate from fire department operations. Ashland Fire & Rescue (AF&R) has always been, and always will be, a fire department first and an ambulance service second. Like most fire departments across the country, we provide “all hazards” responses. Which basically means that we respond to any 911 call (non-police) where a citizen no longer has the ability to take care of the situation themselves. In 1996 we decided that if we were already going to respond to 911 calls for citizens who were sick or injured, why not just provide the next step in patient care and take them to area hospitals. We had the personnel, we had the equipment, we even had a licensed ambulance. By utilizing our firefighters to their fullest potential, we not only provide exceptional service to the citizens of Ashland, we also contribute over one million dollars a year in revenue to the General Fund, helping to offset the cost of the ambulance service.

Prior to taking over the ambulance service in 1996 the fire department had 21 firefighters responding to 1,000 calls a year (Ashland only). Over the last 20 years the number of calls just in Ashland has almost tripled, rising to over 2,800 calls in 2018. In order to respond effectively, the department needs to maintain 27 firefighters (3 shifts of 9 firefighters) to handle this call volume.

To reiterate, even without the ambulance service the fire department will need to respond to 2,800 calls for service, almost a 200% increase in call volume since 1995. The 27 firefighters (currently we have 30) needed to handle those calls only represents a 30% increase in personnel over the same time period. Our call volume and response models will be further discussed during our presentation.



1. What is the cost of the ambulance service separate from fire operations?

<b>Expenses Related to Ambulance Service**</b>	
Eliminate 3 Firefighter/Paramedic Positions	\$ 480,000
Overtime Related to Ambulance Service	\$ 120,000
Bad Debt	\$ 160,000
Dispatch Service (Ambulance Portion)	\$ 61,000
Patient Billing Service	\$ 55,000
Ambulance Supplies	\$ 60,000
Ambulance Leases (5)	\$ 98,000
Ambulance Maintenance	\$ 48,000
Ambulance Fuel	\$ 10,000
County ASA Fee	\$ 7,000
<b>Total</b>	<b>\$1,099,000</b>

\*\*There are several other factors to consider when talking about the cost of the ambulance service. More information has been provided in question #15.

2. What revenue would the City lose if we did not provide ambulance service?

<b>Revenues Related to Ambulance Service</b>	
Patient Transports	\$ 1,080,000
Aid Calls	\$ 20,000
Ambulance Memberships	\$ 68,000
<b>Total</b>	<b>\$ 1,168,000</b>



*3. Are there current policies that could be amended to reduce costs? If so, what would the impact be on current service?*

The union contract states a newly hired firefighter must be at least a certified Emergency Medical Technician (EMT). While we have held the ambulance service (over 20 years), we have only hired Firefighter/Paramedics. The union contract identifies that Paramedics will be paid an incentive that is higher than an EMT. If we were to start hiring Firefighter/EMTs, we could save about 12% on firefighter salaries.

By only having Firefighter/Paramedics we ensure that each patient gets the best care possible. If we move towards hiring EMTs, our ambulances would eventually be staffed with one paramedic and one EMT. This will be a similar ambulance model to what we see with most private providers. It is cheaper but comes with its own set of issues (refer to the second bullet point in Question #6).

If we no longer had the ambulance service, I would imagine that we would begin hiring Firefighter/EMTs to staff our fire engines. We would want to retain a certain number of Paramedics to ensure that we had Advanced Life Support capabilities on our fire engines but we would only need one per crew.

*4. How would the citizens be billed if the City did not provide the ambulance service?*

The ambulance service, whether provided by the City or a private business, is going to bill patients for services rendered. The cost is set by the ambulance service with approval from the Jackson County Board of Commissioners (JCBOC). Currently all three ambulance providers in Jackson County are charging similar rates. It should also be noted that most of the patients transported are covered by Medicare and Medicaid. By law, we must accept the amount offered by the Center for Medicare & Medicaid Services (CMS), and are not allowed to seek the difference between what CMS paid and what we charge (average bill is about \$1200, average CMS payment is about \$400).



*5. Does the City have any influence in the service level of the private service?*

As it currently stands, the ambulance services in Jackson County are regulated by the County Ambulance Service Area (ASA) Plan. ORS 682.031 (3) identifies that a City may not dictate ambulance rules that do not comply with the County ASA Plan. That being said, Jackson County is currently in the process of rewriting the ASA Plan. If the City wished to influence any changes to the plan (for the benefit of Ashland residents), now would be a good time to make suggestions.

Because many jurisdictions are starting to run into issues with the private ambulance sector, the Oregon Fire Chief's Association tried to pass legislation this year that would give local districts and municipalities the power to create ambulance response rules within their boundaries. The bill was heavily opposed by the Oregon State Ambulance Association and died. However, I believe something similar will come up again in future legislative sessions.

*6. What services may the City lose by privatizing?*

-Moving to a private ambulance service would require us to reduce our current staffing by three firefighters (10% reduction in personnel).

-Staffing level on private ambulances would most likely be one Paramedic and one EMT (not two Paramedics). While not mandated, not having two Paramedics on an ambulance may be detrimental in several ways. 1) There is not another Paramedic to consult with on critical patients. 2) All serious calls must be handled by the Paramedic (the EMT will just be driving). This puts a lot of pressure on the Paramedic regarding work load and could have an impact on patient care.

-Not having the ambulance service will require us to respond to all medical emergencies in the fire engines (instead of ambulances). This will ultimately cause the engines to wear out sooner and probably require replacement at an earlier date than currently planned for. Not so much a service issue, more of a cost issue. More details regarding engine responses are detailed in the next question. We will also cover how/why the engines respond in the presentation.



*7. Does your service rely on City Fire Engines to help deliver care? How do you imagine that your service and the City Fire Department would interact in different scenarios?*

We have four fire agencies in our ASA. Ourselves, Jackson County Fire District #5 (JCFD5), Colstein Fire and Greensprings Fire. AF&R does not “rely” on fire engines as part of our ambulance service. However, if engine companies are able to arrive on scene before the ambulance and/or provide additional trained EMS personnel for more serious calls, we recognize that this is a benefit to the patient. For those reasons, each jurisdiction has identified what type of medical calls their engine companies will respond to in order to provide better patient outcomes to the citizens within their boundaries. The fire service commonly refers to this method of response (fire engines first, ambulances second) as a “tiered response”.

In Ashland, we also use a tiered response with our fire engines and ambulances. This model will appear different from neighboring communities because our fire engines and ambulances are stationed in the same location. This means that when a call comes in, the ambulance is just as close as the fire engine. As stated earlier, if the reason for a tiered response is speed and/or more personnel, it is not always necessary to have an AF&R fire engine respond to a call along with the ambulance.

AF&R has identified that a fire engine must respond (in the city limits) with our ambulance to the following types of calls:

Breathing Problems	Motor Vehicle Crash
Chest Pain	Seizures
Cardiac Arrest	Stroke
Diabetic Emergencies	Trauma Injuries
Drownings	Unconscious
Electrocutions	Water Rescue
Heart Problems	Pregnancy Complications

For all other types of calls, only the ambulance is required to respond. One caveat, if the fire engine is closer to a patient (and will thus arrive quicker than the ambulance), the engine will respond regardless of call type.



Here is an example. Let's say an Ashland resident is preparing their morning breakfast. While slicing a bagel they accidentally cut open the palm of their hand. They quickly wrap the wound with a towel and apply direct pressure. The wound is not actively bleeding but is very painful and the resident (who lives alone) is not sure what they should do now. So...they call 911. They tell the dispatcher what has happened, and AF&R is dispatched to the incident. As the laceration is not serious in nature, rapid responses and/or extra personnel are not needed, thus, only the ambulance will respond. The engine will remain in quarters, available for another call.

*8. Please provide the billing structure for the service you provide.*

As the ambulance service provider for ASA III, we are given the exclusive right to transport patients following both State and County laws and regulations. In return, we are allowed to bill patients for this service. Current rates charged by AF&R are:

Ambulance Transport Base Rate -	\$1095
Transport Mileage Rate -	\$14.30 a mile
Non-transport Aid Call -	\$317

It is important to note that the Aid Call listed above is only charged on calls where our paramedics need to provide some sort of intervention or deliver care (as in start an IV and give dextrose for hypoglycemia). If all we do is assess the patient (vitals, physical exam, 12 Lead ECG, etc.), there is no charge to the patient.

Following every call (both fire and EMS), our firefighters are required to enter all of the pertinent information into our records management system (RMS). On medical transports we capture things like response times, response mode, addresses and most important, information about the patient, the patient's condition and what we did to help the patient. If we do transport the patient, we keep track of the mileage from their location to the hospital. Once the call is finished, we create a Patient Care Report (PCR), entering the information into our



RMS. Once complete the PCR is double checked by a Captain and then marked as ready to bill.

Our billing is handled by Fire Recovery EMS (FREMS) billing service. FREMS downloads the PCRs on a daily basis and runs them through their billing software. The goal is to have an invoice generated within 72 hours. FREMS uses several different programs to identify patient insurance information if none was available at time of call. FREMS has an online payment program available for those who need to make payments over time or would like to make credit card payments. Funds collected are direct deposited into City accounts.

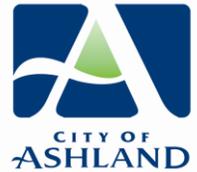
At last check our payor mix was approximately 64% Medicare, 18% Medicaid and 18% Private Pay.

*9. How are ambulances physically located to respond to calls?*

AF&R currently staffs two ambulances full time. One responds from Station 1 (455 Siskiyou Blvd) and the other responds from Station 2 (1860 Ashland St). A third unit is often available that responds from Station 2. Two other reserve units are housed at Station 1. AF&R has conducted several response time studies over the years. The studies have always shown that the current station locations provide the best possible coverage for emergency responses.

*10. What is your policy for upkeep of equipment?*

The Oregon Health Authority (OHA) identifies a minimum list of items each ambulance must carry. Additionally, our supervising physician outlines certain requirements regarding medications that must be carried. Any items found to be missing, defective or outdated are immediately replaced with stock from station inventory. Large items that will need to be serviced (cardiac monitor, gurney, O2 cylinder, etc.) are tagged out of service and a reserve unit is added in its place. Department personnel with area of responsibility will see that the needed repairs are made before the equipment will go back into service. Medications and equipment carried on the ambulances are checked:



DAILY – Controlled medications, Oxygen Delivery Pack, Cardiac Monitor, Medical and Trauma Pack, Pediatric Pack, Ambulance Suction Unit and Main O2.

MONTHLY – Complete inventory of all supplies carried on ambulance, expiration date check on all medications.

The ambulances are our biggest piece of equipment. The following checks take place:

DAILY – Fuel, batteries, oil, tires, mobile data computer and cleanliness.

WEEKLY – Lights, siren, transmission, radiator, radios and complete sterilization.

MONTHLY – Steering, brakes, differential, belts, filters, wipers, exhaust, tires.

Additionally, ambulance checks are performed using a computerized system with department iPads and iPhones. All issues are noted by the system allowing us to monitor recurring problems over time. An issue that cannot be resolved by on-duty personnel creates a work order for our city shops who schedule the vehicle as time permits. If the noted issue is serious in nature, the ambulance is taken out of service and a reserve unit takes its place. The department maintains two reserve ambulances.

*11. What would the cost difference be to lengthen response time? For example, if the standard is 5 minutes, what would 8 or 12 cost?*

That is a little tricky as response times are dictated by the ASA Plan.

Assuming we are still meeting the ASA Plan requirements, lengthened response times (longer waits for patients) could be accomplished by reducing personnel and ambulances. However, as AF&R is a fire department, who happens to transport, we do not have a response model that tries to have the minimum number of units on the road at any given time to handle available calls. As a fire department, we make sure we have adequate staff to handle most hazardous responses and then routinely draw that number down to handle patient transports (what we consider to be an acceptable level of risk).



If we were just an ambulance service, handling a massive call volume, over a huge response area, we would most likely be using some sort of system status management, utilizing the fewest number of ambulances possible to handle calls within dictated time standards.

*12. What training is your staff required to complete? What type/level of certification?*

State certified paramedics are required to renew their licenses every two years. Over the two-year period they must receive at least 48 hours of continuing education on a variety of topics (trauma, medical emergencies, obstetrics, cardiology, etc.). They must also demonstrate skills proficiencies with airway management, cardiac arrests, splinting and immobilization, vascular access and cricothyroidotomy (both needle and surgical). AF&R also requires our paramedics to take an Advanced Cardiac Life Support class and a Pediatric Advanced Life Support class during the two-year recert period (hours for these classes count towards the 48 hours). Additionally, staff must attend at least one case review per year or have at least two hours of contact time with the supervising physician. All personnel will also recertify in CPR yearly.

*13. Who regulates paramedic/ambulance services? Please provide history of inspections/infractions/citations for your agency.*

Regulation of the ambulance service occurs at both the state and county level. The state is responsible for making sure that the ambulance service is licensed on a yearly basis. This includes both the service itself (AF&R) and the ambulances. The county is responsible for making sure that we are staying in compliance with the ASA Plan. The county requires us to submit monthly data regarding response times. They also require us to submit a yearly report that provides information regarding personnel certifications, vehicle maintenance records, membership programs, community service, equipment, training, mutual aid agreements, financial reports and statistical data.



Our last on-site inspection by the OHA occurred in October of 2017. Our facilities, records and ambulances were inspected for compliance with State regulations. At that time there were no deficiencies noted. We do not have records for previous inspections, apparently, they occur on a very infrequent basis, maybe once every 8-10 years.

I am only aware of one official complaint made against AF&R. A patient transported in 2016 filed a complaint with the OHA. The state investigated and concluded that there was no evidence of wrong doing and the case was closed.



14. For the first 6 months of 2019, what was your average response times for county reportable calls in the different zones (urban, suburban, etc.). What percentage of total calls in these zones are deemed to be reportable? For non-emergent (unreportable) calls, what is your average response time in the different zones?

### County Reportable Calls (Emergent)

Zone	Average Response Time (minutes)
Urban	5.04
Suburban	10.59
Rural	21.71
Frontier	28.87
Search and Rescue	34.83

### Non-Reportable Calls (Non-Emergent)

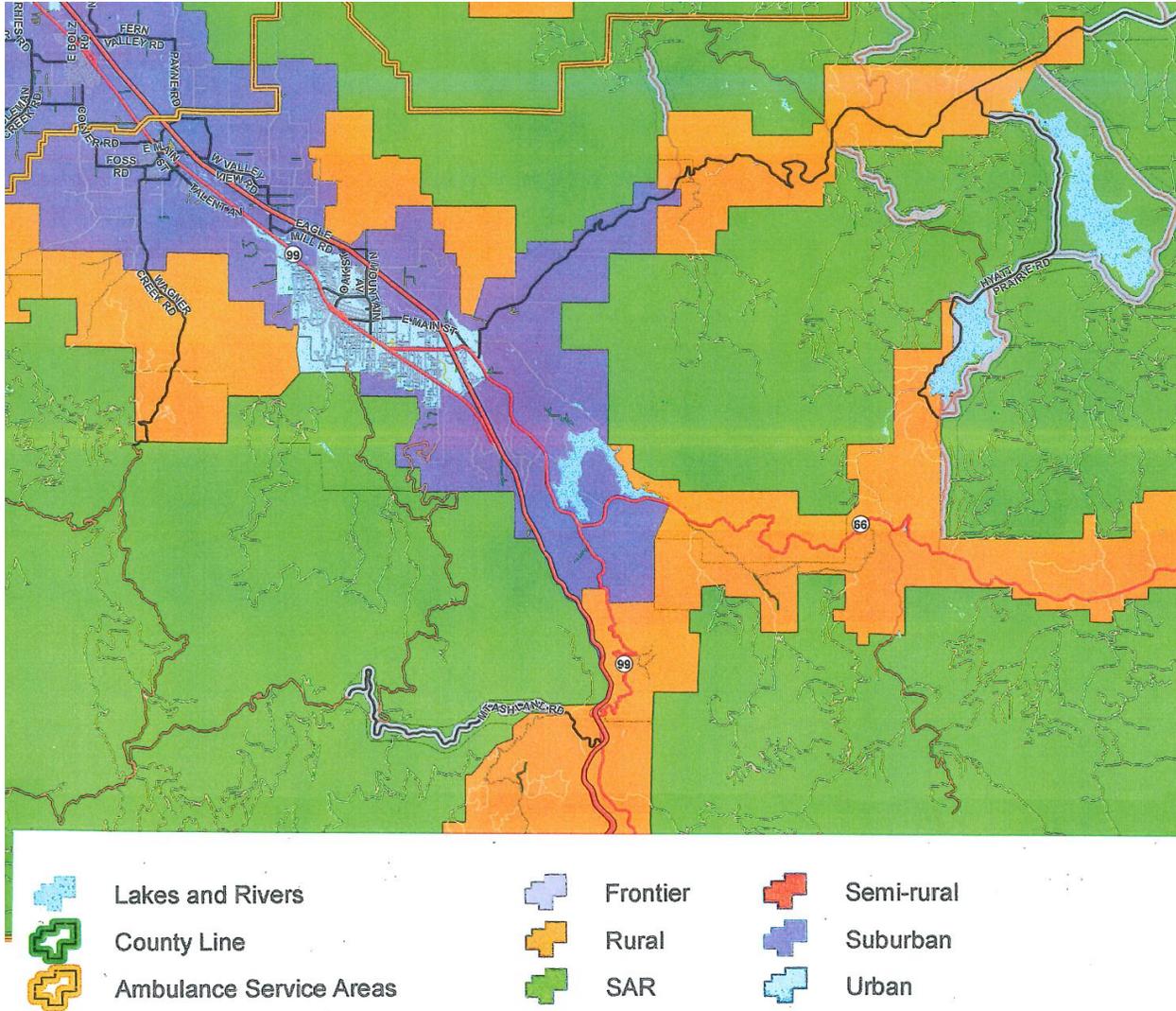
Zone	Average Response Time (minutes)
Urban	6.39
Suburban	11.82
Rural	22.94
Frontier	28.09
Search and Rescue	34.07

### Calls that are Reportable

Zone	% of Total Calls
Urban	46%
Suburban	45%
Rural	58%
Frontier	25%
Search and Rescue	54%

“Reportable Calls” – those calls an agency determines to meet the definition of an acute medical condition (calls requiring a lights and siren response).

### Response Zones – ASA #3



Zone	Mandated Response Times (for reportable calls)
Urban	10 minutes
Suburban	15 minutes
Rural	45 minutes
Frontier	2 hours
Search and Rescue	4 hours



*15. What is (or what would be) the annual taxpayer subsidy required to run your operation?*

When we look at the numbers shown in question #1 & #2, we see that the ambulance service is basically cost neutral, not requiring any additional funds to subsidize the service.

It needs to be noted that those figures in question #1 only represent our current budget cycle. The 2019-2021 Biennial Budget required us to eliminate a chief officer, cut overtime and reduce our materials/services budget.

Since at least 2010, the department has been seeking approval to reach a staffing level of 11 per shift, or 33 firefighters total. As long as we continue to hold the ambulance service, we will continue to advocate for a staffing level of 11 (assuming our call volume holds steady). As long as we hold the ambulance service, we will also need to have some sort of chief officer in place to manage the day to day intricacies of operating an ambulance service. This could be as it was, in the form of a Deputy Fire Chief, or perhaps we could look at a different model, maybe a Battalion Chief of EMS. Bottom line, if we continue to hold the ambulance service, we will need the chief officer position restored and we will continue to advocate for three additional Firefighter/Paramedics.

So..... the answer to the question above has two answers. 1) For the current biennium, we do not require any additional tax subsidies to run our ambulance operations. 2) The department requires at least a \$581,000 annual taxpayer subsidy (three additional Firefighter/Paramedics and a Chief Officer) beginning with the 2021-2023 Biennial Budget.



*16. What is the cost for an average deployment?*

We have determined that each ambulance deployment cost around \$830. This figure was derived from a recent cost per transport analysis that needed to be done for the Ground Emergency Medical Transport reimbursement application.

*17. What is your equipment utilization ratio (average usage per hour)?*

For the first 6 months of 2019, our two primary ambulances were actively on calls approximately 9% of the time, each. That figure is derived from time of dispatch until the unit goes available for next assignment. It is only for the vehicle. If you include time to write patient care report, submit for billing and restock/clean ambulance, we are probably closer to 20%.

A common practice in the EMS industry is to calculate Unit Hour Utilization (UHU). A simple way to see how busy your ambulances are, over any given period. To determine UHU for AF&R for 2018 we could take our total number of transports and divide this by total unit hours. As we typically staff two ambulances a day, our unit hours are 2 (ambulances) x 24 (hours) x 365 (days) = 17,520 hours. Divide this into 2020 (number of transports) and we get an UHU of 0.115. A recent article I read in an EMS trade journal talked about reaching a saturation point (time for more ambulances) at 0.4 UHU.

*18. What are your thoughts on a public/private hybrid model?*

There are many good examples of public fire departments joining with private ambulance services to provide exceptional care to their communities. A much-touted example is the joining of the Contra Costa County Fire Protection District and American Medical Response. The two agencies formed a hybrid model that has features such as:

- Single-source dispatching
- Consistent training for all responders



- Common and shared language and response culture
- Elimination of redundancy
- Single command structure
- Shared facilities

While I am open to the idea of looking at some sort of model, I believe that our relatively small size and call volume would not make operational sense to a private ambulance provider. Having said that, if at some point in time all the Southern Oregon fire departments were to become one district, it would then make sense to look at some sort of collaborative effort to integrate fire and private EMS under one umbrella.

*19. What are your thoughts where first responders show up faster than fully trained paramedics? Or prioritizing calls?*

Similar to #7 above, when a first responder (fire, police, EMS) is able to arrive on scene before the ambulance and/or provide additional trained EMS personnel for more serious calls, we recognize that this is a benefit to the patient. Fire departments delivering quick, compassionate and skilled care to sick and injured citizens was not only a logical progression for the fire service as a whole, it has become the norm for most of the country.

The Rogue Valley Fire Chief's are currently working with our dispatch center to better identify the types and severity of medical calls in order to more accurately dispatch the correct unit(s) in the correct manner (lights and siren, or not). We expect this to be put into place over the next 12 months. Both fire and EMS services currently have the ability to alter their responses based upon the severity of incoming calls (divert from one call to respond to a more urgent call).



20. Do you have any quality of care survey information from patients you can share?

AF&R has not conducted patient surveys for many years now. However, the City routinely asks our residents about services in general. The fire department and its ambulance service consistently score at the top. A couple of those are shown below. If you have time, there follows a great story from one of our cardiac arrest survivors from a few years ago.

From the National Citizens Survey for City of Ashland - 2016

Table 4: Governance by Facet

		Percent rating positively (e.g., excellent/good)			
		2011	2012	2014	2016
Safety	Police	78%	82%	73%	83%
	Fire	92%	96%	94%	97%
	Ambulance/EMS	94%	92%	94%	94%
	Crime prevention	75%	70%	74%	69%
	Fire prevention	81%	86%	86%	87%
	Animal control	NA	55%	62%	56%
	Emergency preparedness	79%	73%	72%	70%

From Engage Ashland – Fall 2018

Below are the percentages of people who rated each service.

	N/A	Needs Work	Average	Excellent
Ashland Fiber Network	31%	12%	<b>29%</b>	28%
City Parks	0%	6%	24%	<b>70%</b>
Electric Utility	2%	22%	<b>43%</b>	33%
Fire & Rescue	4%	1%	22%	<b>73%</b>
Police & Public Safety	0%	15%	35%	<b>50%</b>
Street Maintenance & Repair	4%	<b>43%</b>	30%	22%
Water & Energy Audits	30%	16%	<b>36%</b>	19%
Water Quality	1%	9%	41%	<b>49%</b>
Utility Billing	9%	<b>37%</b>	33%	20%

Refer to the Appendix for individual comments.



## John Lotts Incident

My name is John Lotts. I live in Central Point, Oregon. I am 54 years old, have been married for 31 years to an awesome woman who somehow puts up with me. We have 4 fantastic children that range in age from 13 to 30. Even though we are beginning to spread out, we are still a close-knit family.

I am in pretty good shape and my biggest hobby is running marathons (26.2 miles) and ultras (anything over 26 miles). I am not a super-fast runner but I always finish what I start. In the last 10 years I have run 75 marathons or ultra-marathons as well as innumerable shorter races. I have qualified for and run the Boston Marathon twice. My longest race was 62.5 miles in the mountains near the Willamette Ski resort. I tell you this not to boast but to make it clear that I have a lot of experience in long distance running.

On the morning of November 5, 2016, I started my 76th marathon in the town of Ashland, Oregon. The Lithia Loop Marathon starts at the bottom of Lithia Park, heads up the mountain for 10 miles, flattens out for 6 miles and then heads back to town for the last 10 miles.

I hadn't been feeling 100 percent for several months and had just told my wife a few weeks before that I didn't feel "right" lately. I was having lots of acid reflux at night and I hadn't been recovering from my long runs as quickly as I expected. I attributed the slow recovery to my age. A check-up a few weeks earlier found that my blood pressure was a little high and I was instructed to monitor it. Otherwise, I was looking forward to the upcoming marathon.

The first 10 miles of the race are pretty grueling. I found myself feeling a little nauseous and dealing with some stomach pain. Those things are normal for this type of race but I couldn't shake the feeling that it felt a little different this time. As I reached the top and passed the 12 mile mark, my chest started to hurt. I assumed it was acid reflux and ended up taking some medication that I had brought with me. It didn't seem to help. Every time I tried to run it hurt. When I



stopped the pain was still there. As there was nowhere to stop I pushed on. As I stated earlier, I have done lots of these types of runs and I know what my body is capable of doing. I am familiar with the pain that comes from these endurance events and know that you just can't quit when it hurts. To be a long distance runner you have to be pretty strong willed and especially stubborn. You can't give up at the first feelings of discomfort or you will never finish when things get tough and your body hurts. While the pain of this event was greater than normal I convinced myself that maybe the altitude was part of it.

At the mile 16 aid station I grabbed a quick drink and pushed on. I only made it another 50 yards before the pain caused me to stop and sit down. My whole body was hurting and I knew that I wasn't going to make it down the mountain. This was a huge deal for me. I have never quit any race that I have started and I couldn't accept that I might not complete this one. I convinced myself to keep going and only made it another 25 yards before I had to sit down again. The pain was very intense now and had increased in my chest making it hard to breathe.

I reluctantly turned back to the aid station realizing there was no way I could go 10 more miles like this. Nate Olsen, who was running the aid station, saw me and ran down the road to help me. He is a friend and was aware that I have never quit a race so he knew that something had to be very wrong. By this time my left arm was numb and (funny as it sounds) my teeth were tingling. The pain in my chest had increased 10 fold. It was at that moment that I realized this was something very bad and most likely heart related. As there was no cell phone service at the aid station, Nate and Melissa Steele (the other person at the aid station) got me into a car and we drove down the mountain as fast and safely as possible. At the mile 20 aid station Nate stopped and had them call 911 so that Ashland Fire & Rescue could meet us at the finish line. It took almost 45 minutes to get off the mountain and back into town.

Along the way I continued to have a lot of chest pain. As the fear of what was occurring started to sink in, thoughts of my family helped keep me hopeful. Especially my wife. Her last piece of advice to me the night before was "run smart



and don't push things". Man, was I ever going to be in trouble when she saw me next!!

As Nate drove down the mountain Melissa kept checking to see that I was alive. When we arrived at Lithia Park the crew from Ashland Fire & Rescue was standing by. Firefighter/Paramedics Jim Thomason and his partner Daniel Caples were staffing the ambulance that morning. They got me into the ambulance, hooked me up to the heart monitor and checked my vitals. Amazingly (and unfortunately) the pain and discomfort had gone away. After checking everything out Jim said that things looked okay for the moment and there was no obvious sign of a heart attack. He was under the impression that something had definitely occurred and that I needed to go to the emergency department to be checked out. Knowing the price of an ambulance ride was not in the current budget (I know, sounds dumb doesn't it?), I asked if my wife could drive over to Ashland and take me to the hospital. Jim told me that I did have that choice but he didn't advise it. At this point, his partner Daniel spoke up and said "yes, you do have that choice, but the smart choice is to let us take you now". Those were probably the most fateful words spoken that day. If he hadn't worded it that way he had, and convinced me to go to the hospital in the ambulance, this story would not have had an entirely different ending.

I listened to his advice and off we went. I called my wife and told her not to worry but that I wasn't feeling too hot and that the Paramedics wanted me to go the hospital. I didn't want to tell her it might be heart related and panic her. She planned to meet us at the hospital. As the ambulance was starting to leave downtown Ashland the pain started coming on again. The pain was so intense that I laid my head back and closed my eyes for a second to gain control of it..... That is when I died.

When I woke, Jim was hovering over me, the defibrillator in his hands. He had a look of hope in his eyes. Another Firefighter/Paramedic, Matthew Stewart, had magically appeared in the back of the ambulance and was also anxiously watching me. I remember asking Jim if I had died and if he had brought me back. He answered yes to both. I know it sounds pretty lame but I thanked him for what he did and said "no...thank you".



Apparently, about the time I closed my eyes to fight against the pain my heart went into ventricular fibrillation. I immediately became unconscious and stopped breathing. Recognizing what was occurring, Jim called up to his partner Daniel, who radioed for additional help from the nearby Ashland fire engine. Jim started CPR while Daniel got the ambulance pulled over to the side of the road. While Jim continued CPR, Daniel hooked up the defibrillator pads so they could shock my heart. In the meantime, Matthew, who was on the fire engine joined Jim so that Daniel could continue driving us to the hospital. About one minute after closing my eyes the defibrillator restarted my heart.

Jim advised me that we would be going to Rogue Regional Medical Center as they had a Cardiac Unit standing by and would get me right in. They had the dispatch center call my wife and let her know what was happening and where we were going. I can't begin to explain all of the feelings that were running through my mind during those moments, but I do know that Jim was a big part of why I managed to stay calm. He explained what was happening and what was going to happen when we got the hospital. He was constantly monitoring my vital signs and keeping me apprised of my situation. His poise and calmness reassured me and definitely kept me from panicking.

When we arrived at RRMCC the crew got me out of the ambulance and into the Cardiac Unit. Jim reassured me that they would take care of me and not to worry. I was taken into the Cath lab where another amazing group of people took care of me. Dr. Hong informed me of what she felt was the issue and what they would do to fix it. She made sure that I knew once it was corrected the pain would stop. At one point my heart stopped again and they had to defibrillate me again. So in essence I "died" twice that day. Once the procedure was completed I was rolled into a critical care room where my family was able to see me.

The next day my entire family, all four kids and my wife, were in the room with me when Jim and his partner stopped in to see how I was doing. What an amazing opportunity for my family to thank them in person for saving my life. My wife was able to give them hugs and thanks and we all started crying.



I am very grateful to Nate Olsen and Melissa Steele for their quick thinking and getting me down the mountain swiftly. Dr. Hong and the Cath Lab team at RRMC did an outstanding job of fixing my problem and I am so grateful to Jim and the rest of the Ashland Fire & Rescue crew for everything they did. No question that without their quick response, sound advice and training I wouldn't be here today. They were amazing!! The City of Ashland should be proud to have such an amazing team. I will always be grateful to them for what they did for me.