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Advancing Health in America

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July 19, 2024

The Honorable Douglas Parker
Assistant Secretary
U.S. Department of Labor
Occupational Safety and Health Administration
200 Constitution Avenue, N.W.
Washington, D.C. 20210

Re: Docket No. 2007-0073, Emergency Response Standard (Vol. 89, No. 24), Feb. 5, 2024

Dear Assistant Secretary Parker:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Occupational Safety and Health Administration's (OSHA) proposed emergency response standard.

OSHA's proposed rule would replace its existing fire brigade standard, expanding its scope beyond firefighters to encompass a wide range of emergency personnel, including hospital-based ambulance services. Specifically, hospital-based ambulance services would fall under the proposed rule's definition of emergency service organizations (ESOs).[1] As ESOs, hospital-based ambulance services would be required to meet the rule's voluminous provisions, including those related to written emergency response plans, hazard vulnerability assessments (HVA), training, personal protective equipment, medical screening, behavioral health services, and workplace violence control, among many other requirements. It also would require ESOs to incorporate by reference 22 wide-ranging National Fire Protection Agency (NFPA) standards.

[1] ESOs encompasses employers whose primary function is not as an emergency service provider but have employees whose primary duty for the employer is to perform emergency services.

Ensuring workforce safety is a paramount priority for hospitals and health systems, and the AHA appreciates OSHA's efforts to improve workplace safety for emergency medical services (EMS) workers in ESOs, including hospital-based ambulance services. However, while we share your ultimate objectives, we are concerned that the standards as proposed include provisions that would be impossible to achieve for hospital and health system-based ambulance services. For example, many of the provisions directly relate to the risks faced by firefighters and address situations that do not exist for ambulance personnel. They also fail to account for the myriad regulatory requirements already placed on hospitals and health systems and their ambulance services. In addition, there are several places where the language in the proposed standards is confusing and certain provisions that would be particularly onerous to meet for certain hospital ambulance services, such as those operating in rural areas.

As such, we recommend that OSHA permit hospital-based ambulance service ESOs to meet the proposed standards through existing requirements specific to their operations, such as those required for accreditation by The Joint Commission, other Centers for Medicare & Medicaid Services-approved hospital accreditation bodies, or the Commission for the Accreditation of Ambulance Services (CASS).

The AHA's detailed comments and key concerns about the proposed rule are discussed below.

National Fire Protection Agency Provisions Incorporated by Reference

The proposed rule incorporates by reference 22 NFPA standards. The NFPA standards have been developed mostly by fire-based organizations, including fire equipment manufacturers, labor representatives, enforcement representatives, special experts/interests, and other fire-centric stakeholders. As a result, many of these standards are most appropriate for fire-based ESOs and not representative of the working conditions for non-firefighter ESOs, such as hospital-based ambulance services. Indeed, many of the NFPA standards referenced in the rule would be challenging, if not impossible, for EMS organizations to interpret and comply with, and would be inappropriate for their services.

For example, the NFPA 1582 Standard on Comprehensive Occupational Medical Program for Fire Departments includes a vague description of exposure to combustion products and requires more detailed medical screening and surveillance. It is not clear if this is intended to apply to non-fire-based EMS personnel who may be present at fire scenes. Nevertheless, in such situations, hospital-based ambulance services are kept waiting far from the fire scene, and fire service responders bring patients out of such sites to be treated by the ambulance responders. While this type of medical screening and surveillance is appropriate for firefighters, it is inappropriate for hospital-based ambulance services that are not permitted to enter environments that would expose

them to these substances. Another example is NFPA 1021 Standard for Fire Officer Professional Qualifications (2020 ed). It requires that persons serving in an incident command position at a scene must be trained to the level of Fire Officer I, II, and III. Thus, the OSHA proposed rule would require that non-fire-based EMS officers be trained consistent with this fire-centric standard which requires knowledge of Firefighter II, Fire Instructor I, and related job performance requirements as defined in Sections 4.2 through 4.7 of this standard.

By contrast, the most common accrediting body for EMS is the Commission for the Accreditation of Ambulance Services (CASS), which has standards that are more appropriate for EMS, including hospital-based ambulance services. **As such, we urge OSHA to allow hospital-based ambulance ESOs to comply with the CASS standards rather than the NFPA standards referenced in the proposed rule.**

Community Vulnerability Assessment

The AHA is concerned with hospitals and health systems' ability to comply with the proposed rule provisions requiring ESOs to perform a comprehensive Community Vulnerability Assessment (CVA). This is defined in the rule as "the process of identifying, quantifying, and prioritizing the potential and known vulnerabilities of the overall community that may require emergency service from the ESO, including the community's structures, inhabitants, infrastructure, organizations, and hazardous conditions or processes."

We are particularly concerned about the provision's sweeping wording. While hospitals are required by the Medicare conditions of participation to conduct hazard vulnerability assessments (HVA) of their communities, these are not nearly as expansive as the CVA required by the proposed rule. Hospital-based ESOs do not have, and do not need to have, access to many of the community structures in the area they serve. This is different from fire service ESOs which generally need access to these structures, businesses or other community infrastructure to perform fire inspection responsibilities. As a result, hospital-based ESOs would be unable to meaningfully comply with the CVA requirements in the proposed rule.

AHA members also have expressed concerns about the economic impacts associated with conducting such a comprehensive CVA of the communities they serve. Hospital-based ESOs often cover large geographic footprints; therefore, complying with the proposed rule's CVA requirements would necessitate hiring additional full-time staff just to meet these requirements. This would be a significant and time-consuming undertaking, involving the efforts of multiple individuals from the ESO to perform the duties related to this assessment, including the drafting and maintenance of the CVA and related documents. **Given this, the heavy administrative burdens already imposed on hospitals and the workforce shortages with which they continue to struggle, the AHA recommends that OSHA permit hospital-based ESOs to meet the requirements of the proposed CVA through their existing compliance with the Medicare conditions of participation for conducting an HVA.**

Ambiguous Definitions

The proposed standards incorporate a number of terms without specific definitions. This makes both assessing the proposal, as well as future compliance expectations, unclear and is one of our biggest concerns with the proposed standard. For instance, the proposed standard includes a disjointed and confusing description of covered job duties: "Employers that are emergency service organizations as defined in paragraph (b) of this section, that provide one or more of the following emergency response services as a primary function; or the employees perform the emergency service(s) as a primary duty for the employer: firefighting, EMS, and technical search and rescue. For the purposes of this section, this type of employer is called an Emergency Service Organization (ESO), and the employees are called responders."

It then offers these defined terms:

- "Emergency Service Organization (ESO) means an organization that provides one or more of the following emergency response services as a primary function: firefighting, EMS, and technical search and rescue; or the employees perform the emergency service(s) as a primary duty for the employer" and
- "Personnel (called responders in this section), as part of their regularly assigned duties, respond to emergency incidents to provide service such as firefighting, EMS, and technical search and rescue. It does not include organizations solely engaged in law enforcement, crime prevention, facility security, or similar activities."

The combination of the proposed standard's statement of coverage and these two definitions raises questions about the application of the standard in a variety of scenarios. For instance, would the standard apply when a hospital-based responder is doing administrative work? If the ESO provides both emergency and non-emergency responses, are both functions subject to the standard? Are ESO dispatchers, trainers and others who never engage in front-line emergency responses as part of their day-to-day work considered responders because they "respond" to emergency incidents?

Unfortunately, the proposed standard fails to recognize that a large portion of the work performed by hospital-based responders is not any sort of emergency response, but instead normal day-to-day activities, including various administrative duties and nonemergency patient transport between facilities**. The AHA recommends that OSHA clarify the people and situations in which the standard does not apply, specifically excluding situations when hospital-based ambulances are engaged in nonemergency responses and administrative and other staff that do not engage in front-line emergency response. We also encourage OSHA to examine all the definitions of terms used in the proposed rule to ensure that they are clear and understandable to the regulated community.**

Impact on Hospital-based ESOs in Rural and Super-rural Communities

Of particular concern to the AHA is the potential impact that the proposed rule would have on hospital-based ESOs serving rural and super-rural communities. These ESOs often operate on an extremely limited budget and have very few EMS personnel and ambulances but are at the same time critical to ensuring emergency transport and care access. As is the case for many EMS organizations in the U.S., hospital-based ESOs are experiencing significant challenges with staffing, recruitment and retention of active employees.

The requirements of this rule would place too high of a burden on these already financially stressed hospitals and their ESOs. Indeed, it may very well result in a reduction in their ability to continue to provide critical emergency services. For example, the costs for the proposed equipment, training and administrative requirements all far exceed the limited funding and resources currently available to such ESOs. In addition, the availability of specialized services to fulfill requirements for the proposed extensive employee medical and fitness evaluations simply do not exist in many such communities.

The AHA agrees that it is important to monitor and support the health and safety of our hospital-based ambulance staff. However, the proposed rule goes beyond what is necessary to effectively protect our workforce. Instead, there should be a balance between that effort and strategies that are reasonable and sustainable, many of which are already in place. For example, The Joint Commission, which accredits nearly 90% of U.S. hospitals, already maintains and enforces standards establishing a safety and health management system within hospitals that applies to both patients and employees. There are six core elements comprising such a safety and health management system: management leadership, employee participation, worksite analysis, hazard prevention and control, safety and health training, and annual evaluation.[2]

Therefore, we urge OSHA to consider the unintended consequences of implementing this proposed rule, and specifically the impact it will have on small rural and super-rural hospital-based ESOs and the communities they serve.

Personnel Recruitment and Retention

The proposed rule includes requirements that would negatively impact the ability of hospital-based ESOs to recruit and retain personnel in roles that are already difficult to fill. Specifically, the NFPA has no explicit physical standards for EMS responders. Yet, the proposed rule nevertheless seeks to apply criteria similar to those applicable to

[2] https://www.osha.gov/sites/default/files/2.2_SHMS-JCAHO_comparison_508.pdf

firefighters to EMS personnel, including a variety of requirements related to their physical and medical status.[3]

Although professional firefighters are typically subject to rigorous physical fitness testing prior to hire, most hospital clinical employees, including ambulance responders, are required to pass a basic medical evaluation and physical aptitude test. Increased fire-centric physical and medical requirements, such as those included in the proposed rule, would disqualify a significant portion of those interested in such positions. Moreover, given OSHA's proposed requirements for ongoing medical and physical fitness evaluations, many current hospital-based ambulance employees could be disqualified despite the fact they are licensed, skilled and experienced.

Beyond the initial requirements relative to hiring employees for these roles, the proposed standards would require medical status and health of emergency response employees would need to be subject to employer surveillance and monitoring. The cardiac and pulmonary/respiratory health of providers is the focus of these efforts, with an emphasis on exposures to toxic, hazardous and carcinogenic substances (although the proposed standard does not define those terms), particularly with a focus heavily on the inhalation of the byproducts of combustion. Once again, while this type of employer surveillance and monitoring is appropriate for firefighters, it is inappropriate for hospital-based ambulance services that are often not permitted to enter environments that would expose them to these substances.

Further, under the proposed standard, ESOs would also have to develop fitness programs and make fitness resources available to employees during working hours. This would compel hospital-based EMS services to allow employees to participate in physical fitness programs while working. For many hospital-based ESOs, it is unclear how those obligations would or could be met. Hospital-based ESOs often utilize a high-performance model for their ambulance services, in which a crew of two emergency medical technicians/paramedics are dynamically deployed to a specific geographic area for eight to 12-hour shifts. That geography is then set to specific response time standards, generally with very little downtime. Taking those crews out of service for an hour of exercise while they are working will almost certainly result in gaps in coverage and longer response times for those communities, putting community members seeking emergency care at increased risk.

Finally, the new standard also would establish requirements related to employees' mental health. It would require employers to establish mental health programs that both monitor the mental health of their employees and provide their employees with access to mental health resources, at no cost to the employee. At a minimum, these programs would be required to include diagnostic assessment, short-term counseling, crisis intervention and referral for behavioral health conditions arising from the team

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[3] https://ogletree.com/insights-resources/blog-posts/oshas-proposed-emergency-response-standard-a-closer-look-and-an-analysis-for-covered-employers/

member's or responder's performance of emergency response duties. Hospitals and health systems are acutely aware of the mental health challenges experienced across their communities, including within their own workforces. They are taking a number of steps to connect patients, community-members and workers alike to the necessary mental health services and supports. However, in many communities across the nation, shortages of behavioral health providers has challenged hospitals' and health systems' efforts. While we appreciate that the standards related to mental health service access are well-intended, the AHA is concerned that there would not be enough providers available to conduct such behavioral health assessments at no cost to responders.

As discussed above, the AHA urges OSHA to allow hospital-based ambulance services to comply with the CASS standards rather than impose these fire-centric standards in the proposed rule.

Training, Including Vehicle Operating Training

The OSHA proposed rule would require that each person in an emergency vehicle wear a seat belt or safety harness before the vehicle moves. **The AHA recommends that OSHA revise this requirement to include exceptions in cases where seatbelts are inaccessible**. For instance, in specialized vehicles utilized for infectious diseases, the interior of an ambulance is draped to reduce contamination, including on a seatbelt. Personal protective equipment worn in these cases could potentially be torn when wearing a seatbelt exposing the responder to harm.

Compliance Timelines

OSHA has proposed a phased-in timeline for compliance with the proposed standard, starting six months after the final rule's effective date for certain provisions (e.g., mental and physical health requirements), 12 months for other provisions (e.g., health and fitness program) and 24 months for the remaining provisions (e.g., annual skill evaluation).

While the AHA appreciates OSHA's intent to advance emergency responder health and safety, we believe that the timeline for implementation is far too short and will put hospital-based ESOs at a large and inappropriate risk of noncompliance. **The AHA recommends that OSHA extend the start of the implementation timeline for all provisions by at least two years and allow for longer periods for phasing in the various requirements to provide hospital-based ESOs adequate time to review and develop a plan for compliance with the final rule**.

Conclusion

The AHA, together with our hospitals and health systems, remains committed to ensuring that all our employees can work in a hazard-free and safe environment, including our hospital-based ambulance services. However, we have serious concerns

about the impact that this proposed rule would have on employee recruitment and retention as well as the financial hardship it would create for hospital-based ESOs, particularly those located in rural and other underserved communities. We urge OSHA to make the modifications recommended above, which will both ensure a hazard-free and safe working environment and continued access to care.

The AHA appreciates your consideration of these issues. Please contact me if you have questions or feel free to have a member of your team contact Roslyne Schulman, AHA's director for policy, at rschulman@aha.org.

Sincerely,

/s/

Molly Smith
Group Vice President
Public Policy