TO: **Oregon OSHA**
Sent via email: tech.web@oregon.gov

FR: **Oregon State Ambulance Association**
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RE: **Draft COVID-19 Temporary Standard dated Aug. 17, 2020**

The Oregon State Ambulance Association (OSAA) represents all types of ambulance providers in Oregon —public, private, volunteer, non-profit, emergent and non-emergent, ground and air. Our members serve patients across the State and are truly on the front-lines providing care to presumed and confirmed COVID-19 patients in the field, performing COVID testing and responding to 911 calls. OSAA strongly supports the goal of the Temporary Rules to reduce the spread of COVID-19.

OSAA members were quick to adapt their practices early on—even before the Governor's Executive Order declaring an emergency. Our members are also constantly updating their practices to align with Centers for Disease Control (CDC) and Oregon Health Authority (OHA) guidelines on COVID-19. The success of our members efforts are self-evident, considering the low infection rate of Emergency Medical Services (EMS) workers—even though these same workers are dealing daily with positive and presumed positive COVID-19 patients.

Before OSHA entertains adding an additional layer of regulations on EMS providers, we urge you to consider two things: 1) current regulations and 2) the problem OSHA is attempting to solve. As an industry, EMS providers look for EMS-specific guidance and the leading authority on COVID-19 EMS best practices is the CDC. In Oregon, EMS is also highly regulated by the Oregon Health Authority and the Oregon Medical Board.

OHA guidance incorporates by reference CDC requirements for EMS providers and employers, which can be found here. EMS employers are also required to adhere to The Ryan White HIV/AIDS Treatment Extension Act of 2009, which has been updated to include COVID-19. Additionally, OHA (through CDC guidelines) requires that EMS employers:

- Develop IPC policies and procedures for EMS units that include a recommended sequence for safely donning and doffing PPE.
- Provide all EMS personnel with job- or task-specific education and training on preventing transmission of infectious agents, including refresher training.

- Ensure that EMS personnel are educated, trained, and have practiced the appropriate use of PPE prior to caring for a patient, including attention to correct use of PPE and preventing self-contamination and contamination of environmental surfaces during the process of removing such equipment.
- As part of the Occupational Safety and Health Administration (OSHA) respiratory protection program, ensure EMS personnel are medically cleared, trained, and fit tested for respiratory protection device use (e.g., N95 filtering facepiece respirator), or medically cleared and trained in the use of an alternative respiratory protection device (e.g., loose fitting powered air-purifying respirator, PAPR) whenever respirators are required. OSHA has a number of respiratory training videosexternal icon.
- EMS units should be provided adequate supplies (e.g., hand sanitizer, cleaning supplies, EPA-registered hospital disinfectants, PPE) so EMS personnel can adhere to recommended IPC practices.
- Ensure that EMS personnel and professional cleaners contracted by the EMS employer tasked to clean and disinfect transport vehicles and equipment are educated, trained, and have practiced the process according to EPA-registered label instructions, equipment manufacturer's instructions, and the EMS agency's standard operating procedures.

OHA guidelines also require EMS employees, visitors, and patients be screened for symptoms. Employees, at the beginning of a shift and visitors and patients as they come into contact with the system. There are further guidelines in place for treating a patient who is confirmed or presumed-positive for COVID-19.

The Oregon Health Authority has also implemented further requirements on the EMS system, including:

- Screening of patients at the 911 call center. If a patient is suspected or confirmed to be COVID-19 positive, OHA states that EMS providers:
    1. Involve the fewest EMS personnel required to minimize possible exposures.
    2. Ensure that the patient is masked.
    3. Provide medical care per protocol.
    4. Ensure that healthcare personnel use contact, droplet AND airborne precautions, as follows:
        a. A single pair of disposable patient examination gloves.
        b. Disposable isolation gown. If there are shortages of gowns, they should be prioritized for aerosol-generating procedures, and care activities where splashes and sprays are anticipated.
        c. Respiratory protection (i.e., N-95 or higher-level respirator). If running low on respirators, facemasks are an acceptable alternative. Respirators should be prioritized for procedures that are likely to generate respiratory aerosols. *
        d. Eye protection (i.e., goggles or disposable face shield that fully covers the front and sides of the face)

5. Use caution with aerosol generating procedures and ventilate ambulance if possible.
6. Notify the receiving hospital (according to local protocols) of potential infection as soon as possible.
7. Disinfect using EPA registered Disinfectants for Use Against SARS-CoV-2.
8. Follow local public health authority policies for reporting and follow up of health care workers with contact to suspected cases.

OHA has also established guidance in place for work exclusion of an EMS worker who is symptomatic or tests positive for COVID-19. This guidance includes requirements on employee education. And all of these guidelines are enforced with civil penalties as necessary from OHA.

As well, OHA EMS OAR 333-250-0250 states that EMS providers must comply with all local, state and federal laws. These include OSHA's Bloodborne Pathogens standard (29 CFR 1910.1030) which provides protection of workers from exposures to blood and body fluids that may contain bloodborne infectious agents; OSHA's Personal Protective Equipment standard (29 CFR 1910.132) and Respiratory Protection standard (29 CFR 1910.134) which provide protection for workers when exposed to contact, droplet and airborne transmissible infectious agents.

Finally, OHA has long-required that EMS agencies to make available an infection control plan upon request.

Accordingly, we ask OR-OSHA to provide Oregon EMS providers with a similar exception as that provided to schools:

> *Exemption: EMS providers that develop and fully implement a written program consistent with guidance issued by the Oregon Health Authority is exempt from the requirements of this rule.*

Without an outright exemption, these rules will have a significant impact on the ability to provide ambulance service in Oregon. At a minimum, without an exemption the following changes are needed to continue emergency response:

Section by Section concerns:

(2) COVID-19 Requirements for All Workplaces

Overall, the majority of the components in Section 2 are not practically possible for the unique "workplace" that is an ambulance/EMS provider. What is the definition of "workplace"? The ambulance? The bay station? When looked at through the lens of an EMS provider, you will see why it makes senses this field continues to be regulated by the appropriate agency – OHA.

One of our most significant concerns is with (2)(a)(C) as the kind of distancing is not possible in an ambulance, especially when providing care for a patient. It is also unnecessary if the employee is donned in PPE, which they would be required to do under (2)(b).

(2)(b), the face covering requirement, also will prove practically frustrating for EMS providers. Generally, it is a requirement for patients to don face masks. But, there are some cases where doing so would not be safe due to the patient's medical condition. This portion of the rule does not provide necessary exceptions.

The sanitation requirement outlined in (2)(c)(A) is not possible in cases where more than one EMS provider is providing care for a patient. Alternate language could be:

> *(A) All shared equipment and high-touch surfaces must be cleaned ~~before use by another employee~~ between patient care episodes.*

(2)(g)(B) is concerning in that it creates an unfunded mandate for employee leave programs, at a time when ambulance providers are struggling financially—from decreased call volume, additional PPE costs and a shift in the payer mix (8.6% increase in Medicaid enrollment since the beginning of the pandemic—Medicaid reimbursements are notoriously low, and do not cover the cost to provide care).

(3) COVID-19 Requirements for Workplaces at Heightened Risk

Generally, this section is overly burdensome and portions will be very difficult, if not impossible, to comply with for EMS providers in the field responding to an average of thousands of calls a week.

Emergency medicine, by nature, is unpredictable. The burdensome process outlined in the Exposure Risk Assessment of estimating person-to-person interactions on any given day, for example, would be an exercise in futility and require almost full time staffing for data assessment with no measurable benefit.

(3) COVID-19 Requirements for Workplaces at Exceptional Risk

Our comments are similar for (4) as they are for (3). OSAA members do not have the funding available to craft an "Infectious Control Plan" on a facility-by-facility basis. As well, our members do not have facilities, they operate in ambulances, non-emergency transport vehicles, and in patient's homes across the community, and accordingly have a footprint statewide.

In closing, EMS is already highly regulated, and many of the goals housed within these proposed OSHA rules are already accomplished by existing guidance from the state and federal levels. As evident by the low amount rate of infection amongst EMS workers, this guidance is working to

prevent the spread of COVID-19— a goal we all share. As such, adding another layer of administrative burden on the EMS system is unnecessary. Without an outright exemption, these proposed rules will have a significant impact on the ability to provide ambulance service in Oregon.