

EMSCC AMBULANCE OPS AND LEGISLATIVE SUBCOMMITTEES

MINUTES

June 06, 2024

8 a.m. – 12 p.m.

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248-509-0316 Access Code: 437 543 930#

Committee Members:

AMBULANCE OPS: Monty Nye – chair, Aaron Sogge, Bill Forbush, , Eric Snidersich, Dustin Hawley, Jason Bestard, Ralph Ortiz.

LEGISLATIVE: Bruce Trevithick – chair, Monty Nye, Greg Flynn, Ken Cummings, Lance Corey, Bob Miljan, Alyson Sundberg.

Absent: Jeff White, Kraig Dodge, Curtis LeSage, Dr. Brent, Paul Hood, Lauren LaPine, Jonathan Pyka, Brandon Whipple, Tim Niggemeyer, Angela Madden.

Guests: Kelsey Ostergren, Brian Scribner, Jason MacDonald, Carol Robinet, Tim Miner.

Bureau Staff: Babb, Flory, Baker, Kerr, Bergquist, Biliti, Dr. Fales, Fitzpatrick.

The meeting started at 8:02 a.m. It was decided yesterday to run these meetings as work groups.

To Note (from 6/5/2024 meeting):

- The comment period was extended until July 22.
- Very few participants have read the entire 608 pages.
- Derek Flory summarized the following:
 - There are definitions of who it affects.
 - All life support agencies and fire departments in the state.
 - It goes into the background of why the old Fire Brigade rules need updated.
 - It goes into paragraph by paragraph what the requirements are.
- The overview videos sent out were discussed. It was decided not to watch any of the videos during the meeting time.
- What the product of these meetings should be was discussed. The feedback will be based on the following OSHA document, however, this document is only the specific questions they are asking and does not address the whole rule set: [QUESTIONS AND ISSUES COMPILED FROM THE EMERGENCY RESPONSE NOTICE OF PROPOSED RULEMAKING](#).
- Michigan is a state that with an OSHA-approved State Plan so items that reference not having an OSHA-approved State Plan do not require comment. MIOSHA is the State-approved plan.
- Federal Register (page 7774 to 8023) being referenced in these minutes is located [here](#).
- Tim Miner shared the American Ambulance Association [video](#) on how these rules are expected to impact EMS.

Post Incident Analysis:

R-1: This is referenced on **page 7841**. These are commonly called hot wash or after-action reports. This is similar to the Emergency Response Plan Development question (E-1). Lance Corey discussed criteria. Greg Flynn said it would go by the program developed by agencies. Bruce Trevithick said it is vague for EMS.

- **No comment.**

Portable Fire Extinguishers: Skip.

Heat: This goes to **page 7801** and is asking if standards are desired for this section. Greg Flynn said this is only one paragraph and specific to non-emergent items, such as training. Monty Nye said this is referred to as "[WetBulb Globe Index](#)". EMS being on standby was discussed, and that is not included. This would be for things like training. This would not hurt and protect workers.

- **No comment.**

Consensus Standards: Tim Miner said they should look to bodies like CAAS, air medical, etc.

- **Comment: They should look to all industry participants that have standards rather than looking to one body. Such as CAAS, air medical, etc.**
- **Action item: Create a list of accrediting bodies.**
 - [CAAS](#), [CAMTS](#), [CFAI](#), [NEMSMA](#), [NAAMTA](#)

Profile of Affected Industries: The group discussed. Most WEREs would not be licensed agencies, though there are some that are licensed agencies. For EMS, the state could provide some of the data they are asking for. A number of providers could be given. Volunteers would be those that self-identified as volunteers. Whether or not MIOSHA is making comments was discussed. Emily will write up a report response for paragraph three. This is included below.

- **6/13/2024: Our best estimate of number of volunteers is 2,522. This number was obtained by counting the staff for the agencies that identify as volunteer agencies with our office. A volunteer agency is one that does not charge for its services.**

- **Response to paragraph three:**

The EMS workforce universe needs to be assessed utilizing several layers of data. The number of people licensed is only one component.

Licensees as of 6/1/2024:

User Primary License Level total

Specialist/AEMT 301

Medical First Responder 5,487

Paramedic 9,322

Emergency Medical Technician 14,127

Total: 29,237

Whether or not these licensees are affiliated with an EMS agency is another component. In Michigan, we can use our licensing platform to assess this information.

As of 4/2024, in Michigan:

Affiliations	Medical First Responder	Emergency Medical Technician	Specialist/AEMT	Paramedic
No Affiliated Services	1,615	5,924	94	2,857
One Affiliated Service	3,675	6,599	144	5,338
Two Affiliated Services	231	1,226	45	909
Three or More Affiliated Services	16	241	19	227
Level Totals	5,537	13,990	302	9,331

Finally, utilizing the EMS data system, we can assess the number of active license numbers associated with records inside the Michigan EMS Information System (MI EMSIS).

From 1/1/2024 to 4/30/2024, the number of licensees appearing in at least ONE record in MI EMSIS is as follows.

License Level	Reporting
MFR	2338
EMT	6380
AEMT	149
Paramedic	5208

No one singular component can give a picture of the entire universe, all resources available must be utilized.

Cost of Compliance: It is unknown if Michigan utilizes incarcerated individuals for any of this work.

- **Comment: Michigan requires continuing education based on license level, not ESO size.**

Benefits: The group discussed. Tim Miner said USDOL tracks some information on the OSHA logs. Greg Flynn said this is a broader discussion that could be had at EMSCC. Ken Cummings said information doesn't flow further than the insurance/worker's compensation piece. Level of transparency is questionable due to potential insurance things. Regardless, there is no data to give them. MIOSHA or agencies or other entities could collect data on this.

- **No comment.**
- **Emily Bergquist reached out to the chronic disease section, and they didn't have data or comments to add.**

Economic Feasibility: The group discussed. Greg Flynn referred to **page 7832**. Tim Miner spoke about the cost collection survey from AAA was a helpful tool. This question is for municipalities. This is for public entities to respond to, not for this group.

- **Comment: We also recognize there needs to be a standard for economic feasibility. Inflationary and other economic indicators should be considered.**

Initial Regulatory Flexibility Analysis:

Emily Bergquist said we could send this section to MCRH and MiREMS and say these sections specifically refer to rural areas and ask them to please take time to provide comments on your own behalf.

- **Emily Bergquist sent this to MCRH and MiREMS and they both advised they would disseminate to their groups.**

Miscellaneous: Greg Flynn said there is a big push earlier in the document about a lot of research on cardiovascular disease for ESOs. Ken Cummings and Tim Miner discussed that there are programs out there and some are doing that but that's part of injury prevention program. It's preventative.

- **Comment: There are existing programs. Agencies are creating performance-based objectives.**

Screening process that's less stringent could be done annually.

- **Emily Bergquist sent paragraph three to the chronic disease section, and they didn't have data or comments to add.**

Timeline for Compliance: The group discussed. It is difficult to suggest a time when the standards are not complete. Would they be able to ask for time to provide feedback once additional items are added? The consensus was it will take AT LEAST three years to implement. Greg Flynn said we should give a number, rather than a range.

- **Comment: Until the final rules are published, it is difficult to establish a timeline for compliance period. We would imagine it would take at least two years to implement these type of changes. There will be agencies that have to hire and develop. Five years might be more reasonable for implementation. Just risk reduction alone could take three years.**

Information Collection and Recordkeeping: Skip.

Medical Screening and Surveillance: Returning to this section from yesterday's discussion. Tim Miner spoke about more separation between types of ESO providers in this section. Soley EMS providers could do "blank" for EMS medical evaluation on preemployment, and every two years propose using the word screening rather than evaluation. He said this is where the most financial and administrative burden is coming from this section. Greg Flynn read from **page 7820 and 7821** about OSHA's expectations to provide context. Eric Snidersich said the context alleviates some of his concerns. The group discussed the requirements and how to satisfy them. This should be in your policy manuals, and someone should be overseeing it. Tim Miner said one of the questions they submitted was if you already have a program towards employee health, even if voluntary, does that count. It has to be available during work hours. Ralph Ortiz said we are generally in favor in supporting physical fitness in our employees. It doesn't say they have to use it. Dr. Fales spoke about out of work burden. Greg Flynn said this is ways to set employees up to be successful. Ken Cummings spoke about employer vs employee responsibility. This is referenced starting on **page 7814**.

G-1: Medical screening is the focus of this section. Ken Cummings said he appreciates the broadness but also wishes it was a little clearer. Dr. Fales said he thinks this is handled reasonably well by OSHA well and puts the charge back on the organizations to think about these things and discussed. Tim Miner said there are a couple of words that make him nervous, such as "screening" isn't clearly defined, and discussed. Cost of fitness for duty for everyone every year adds up. For context, Derek Flory said there is a huge emphasis on cardiac arrest in the preamble, and they are using reducing that as justification. Greg referred the group to **page 7820 and 7821** again and discussed. Tim Miner said where it gets cloudy is the spirit of the document versus the enforcement.

- **Comment: Support the idea of the addition of definitions for "screening" and "health evaluation" being included in definitions section of the document.**

G-2: Would support higher level of exposures. This is also murky on **page 7818**. This should be specific to those primary fire. Sole provider EMS shouldn't be included. There are studies out there that show fire fighter cancers are related to their job and there are not studies for EMS. Ralph Ortiz said EMS may be getting some exposure on standby at a fire scene. IAFC report was discussed. Tim Miner said the only test for IDLH they do right now is carbon monoxide. IDLH should be in policy for stand by staff.

- **Comment: Regarding the evaluation criteria discussed, we concur with the following and believe there should be a distinct separation of fire-based providers and strictly EMS**

providers based on job task analysis and risk assessment," Matt Tobia, a subcommittee member representing the IAFC, reported at a subcommittee meeting that a subgroup that discussed medical requirements considered those emergency responders whose job duties required them to enter an IDLH environment to be the responders subject to the full medical requirements (Document ID OSHA–2015–0019–0006, Tr. 108–111).

G-3:Skip.

G-4:No comment.

G-5:No comment.

G-6: Rule should still apply whether WERE or licensed agency. **No comment.**

Next meeting is June 17 from 8 a.m. to 10 a.m.

Next steps: Send this out to the group.