NATIONAL ADVISORY COMMITTEE ON OCCUPATIONAL SAFETY AND HEALTH

MEETING OF SUBCOMMITTEE FOR EMERGENCY RESPONSE AND PREPAREDNESS

Tuesday, December 8, 2015

9:00 a.m.

U.S. Department of Labor

200 Constitution Avenue, N.W.

Room C-5320, Room 6

Washington, D.C. 20210

Diversified Reporting Services, Inc.

(202) 467-9200

PARTICIPANTS:

Lamont Byrd (Co-chair)

Rick Ingram (Co-chair)

Matt Chibbaro

Lisa Delaney

Grady DeVilbiss

Kenn Fontinot

Bill Hamilton

Andy Levinson

Pat Morrison

Kathy Robinson

Sarah Shortall

Anne Soiza

Victor Stagnaro

Chris Trahan

Chris Treml

Matt Tobia

William Troup

Bill Warren

Ken Willette

C O N T E N T S

P R O C E E D I N G S

MR. BYRD: Everyone, we'd like to call the meeting to order. I'm Lamont Byrd. I'm safety and health director at the International Brotherhood of Teamsters. I am co-chair.

MR. INGRAM: My name is Rick Ingram. I work for BP in Houston, Texas, and I also chair the National Steps Network, which is an all-volunteer organization and for health and safety in oil and gas.

MR. BYRD: We'd like to welcome you to the second convening of the Emergency Response and Preparedness Subcommittee of NACOSH. We have a pretty full schedule today. I think that we will have an opportunity to have a discussion about what was discussed during our last meeting, introduce some new topics and get your input.

MR. INGRAM: I just want to thank everybody for coming as well, and thank you so much for all the work between the meetings. We have some subgroups working, and we'll hear from them a little bit later. So thanks to everyone who attended.

And we'd like to go ahead and introduce the

members, and how about if we start over here with Victor?

MR. STAGNARO: My name is Victor Stagnaro. I'm with the National Fallen Firefighters Foundation here on behalf of Chief Ron Siarnicki.

MR. TROUP: Bill Troup, U.S. Fire Administration, National Fire Data Center.

MR. WARREN: Bill Warren, the Arizona division of Occupational Safety and Health.

MR. MORRISON; Pat Morrison, International Association of Fire Fighters.

MS. ROBINSON: Kathy Robinson, National Association of State EMS Officials.

MS. TRAHAN: Chris Trahan, North America's Building Trades Unions.

MR. LEVINSON: Andy Levinson, deputy director of Standards and Guidance at OSHA and the designated federal official.

MS. SHORTALL: Good morning. I'm Sarah Shortall. I'm from the solicitor's office, and I'm the counsel to NACOSH.

MS. DELANEY: Good morning. My name's Lisa

Delaney. I'm with NIOSH.

MR. FONTENOT: This is Kenn Fontenot. I'm with the National Volunteer Fire Counsel.

MR. WILLETTE: Ken Willette, National Fire Protection.

MR. DEVILBISS: Grady DeVilbiss here representing Virginia Department of Labor and Industry.

MR. TOBIA: Good morning. Matt Tobia, International Association of Fire Chiefs.

MR. TREML: Chris Treml, Operating Engineers.

MR. BYRD: Okay. Thank you all very much.

(Conversation off-mic.)

MR. BYRD: Yeah, if we could get OSHA staff to introduce themselves.

(Introductions off-mic.)

MR. BYRD: Okay. Thank you very much. At this point, I would like to ask our counsel, Sarah Shortall, to give us our instructions.

MS. SHORTALL: Okay. I'm just going to go over a few procedural items here, and then Andy will also be doing some as well. Good morning. Welcome, everyone. I'm here as the NACOSH counsel to make sure

the procedure requirements are met for the Federal Advisor Committee Act and also for Osha's regulations on NACOSH. NACOSH has specific regulations that most other advisor committees do not have.

We require that our subcommittee meetings, in addition to our parent committee meetings be held in public with notice on the record, that there be a verbatim transcript and also minutes of the meeting. In a few minutes, you're going to be considering the minutes of the last meeting.

All of those items are going to be placed into the record of this meeting, and they will be part of NACOSH's overall public docket. And on your agenda here is listed the docket number for everything pertaining to this subcommittee, which is OSHA-20150019.

Throughout this meeting I will be entering various items into the record so you'll be able to locate them quickly when you go to regulations.gov to access them. If there is any copyrighted material, it would go into the record, but it may not be posted on our webpage unless we get specific permission.

To help our transcriptionist here, I'm going to ask that each of you, at least for the morning, identify yourselves by name when you speak so that he will be able to get that into the record. Then he will become familiar with your names and won't need it.

Same for the audience, when you speak, would you please also give your names and if you can when you're invited to comment get to one of our microphones.

Anyone have any questions at all, I'll be glad to answer them during the break. So once again, welcome.

MR. LEVINSON: So let me cover briefly shelter in place and emergency rules. This room is a shelter in place in the event that there is a shelter in place emergency. In the event that there's an evacuation, follow people out of the building to one of the collection points. The closest one, I think, is down the stairs if you go out here and then down that way. But you can follow OSHA staff.

There are bathrooms to the left and right of the hallway. Look for the water fountains.

MS. SHORTALL: As we begin to go into the substantive part of this meeting, I would like to enter into the record the agenda for the December 8, 2015 Emergency Response and Preparedness Subcommittee of NACOSH as Exhibit 1.

MR. INGRAM: We're going to be reviewing the meeting summary from September 9th in just a minute, but I thought it would be good to read the charge to NACOSH. And our original title was Emergency Response and Preparedness Subcommittee. That might change. We'll see. We're just getting started for those of you who have not attended a meeting before. So we do have a lot of work ahead of us, but we're making good progress so far.

So this is the charge, and I'm going to read just the first paragraph. OSHA has requested that NACOSH provide advice and recommendations to the Secretary of Labor on proposed emergency response and preparedness standard. To assist NACOSH with this project, OSHA has established an emergency response and preparedness subcommittee consisting of experts who have extensive knowledge and experience in emergency

response and preparedness. The purpose of and charge to the subcommittee is to develop recommendations, including regulatory text for a proposed rule for NACOSH to consider. After deliberations, NACOSH will submit its recommendations and proposed regulatory text to the Secretary through OSHA.

Is that all right, Sarah?

I have an attorney on the left of me here, so she'll poke me -- you might see her poking me every once in a while.

MS. SHORTALL: We've got a real problem here. Usually we have skirts on the table, which allows me to come over and give him a swift kick if he needs to do something. I don't have that protection today, so we'll be very gentle with Mr. Ingram.

MR. INGRAM: All right.

MR. DEVILBISS: Please feel free to respond as necessary.

MR. INGRAM: Okay. So do you want to do the meeting summary?

MR. BYRD: Sure. In your packet, there is a meeting summary. And hopefully the subcommittee

members have had an opportunity to review this document. In the interest of time, although we're just getting started, we have a lot of work ahead of us as Rick stated earlier. Does anyone have any thoughts, comments or revisions to this meeting summary?

Yes, Chris Trahan.

MS. TRAHAN: Hi. Chris Trahan. I did notice that on page 7 of the meeting summary, Chris Treml is identified as a subcommittee member for subgroup one, and that was Chris Trahan that it should be. Me, that's correct, right, Chris? Okay. That's all. Thank you.

MR. BYRD: Okay. Thank you. Are there any other comments or corrections?

(Participant off-mic.)

MR. BYRD: At this point, if there are no other questions, comments or corrections, I'd like to invite a motion to accept the meeting summary as our minutes.

PARTICIPANT: So moved.

MR. BYRD: Okay.

PARTICIPANT: Second.

MR. BYRD: We have a motion and a second. All in favor?

(Chorus of ayes.)

MR. BYRD: Okay. Thank you.

MS. SHORTALL: At this time then, I'd like to enter the record as Exhibit Number 2, the revised minutes from the September 9, 2015 Emergency Response and Preparedness Subcommittee meeting.

MR. INGRAM: And at this time I don't know -- Bill or Randy is going to review the changes made to the draft regulatory language based on the September 9th meeting.

MR. HAMILTON: I apologize for a few things. I'm not sure what happened with our setup. We were supposed to have bed skirts -- not bed skirts, listen to me. We were supposed to have table skirts, we should have another table down here with a microphone. We should have sign-in sheets. The sign-in sheets should be here soon. Please, especially for folks back here, sign the sign-in sheets as guests, interested parties, media and anybody wishing to speak publicly. The sign-in sheets will be there, and we'll see about

getting everything taken care of for the next meeting that we logistically seem to be missing today.

So we're going to review, if you will, please, the changes to the draft language that we prepared for discussion. It's the one with all the track changes on it. And you see that the first track change made in the little box is that essentially everything that I changed was based on comments that you all made in the last meeting or added for clarity based on some of those comments.

And so just going down through it in A scope I, we had talked about law enforcement, and we had had it as a footnote previously. I moved it up to the be the note under A1i. And also there's a section or a note, if you will, because we had said before that the -- there were entities that provided as a primary function or the workers had as their primary function firefighting and rescuing and realized that it may be that, especially in some of the public safety sectors where there -- it may be that they ride around in police cars, but they have turnout gear or rescue gear in the back of the police car, their primary function

is law enforcement, but they do have that secondary function as firefighter rescuers. So just put that in there as a note, as a question to something that we need to keep in mind or need to think about as we clarify the language further down.

In A1ii, there was a suggestion to replace the word "fire brigade" because it's an older term, and so we instead inserted "worker emergency response team," which then does also encompass everything that's in the parens of emergency industrial fire brigade, emergency facility brigades, industrial fire departments, what have you.

And so I changed that term and then carried that term further, you know, as we used it throughout the rest of the document, and we also provided a definition for it because in the previous document we did not have a definition for fire brigade. So this time we did put a definition for the workplace emergency response teams.

On the next page, under iii, there was a recommendation to change skilled support responder to skilled support workers. And so we did that at your

suggestion, and then that caused through the rest of the document anywhere where we had said "responder," which could have been a regular fire, emergency, EMS, rescuer, responder or a skilled support responder, we were using this generic term "responder." As it carries forward, there's places where it says "responder" or "skilled support worker," and you'll see that as we get further along the page.

Crossed off under the paragraph, under number two, was -- it was suggested that it looked like a loophole, it acts like a loophole, and it should be moved to risk management section, which I did, and there's further discussion of it down there, and then added the piece, a new two, and it's -- a new number two. It's in there as a placeholder based on the group that -- the subgroup that worked on the transition point in determining when this -- the scope of this rule applies to when the other general industry or construction industry rules apply. So that's just a placeholder for that, and I know we don't like the language, but like I said, it's just a placeholder to place hold.

Just carrying through down into duty, there's the first example of replacing the term "fire brigade" with "emergency response," and we added in "correctional facility response teams" as an example of an in-place facility, because we had issues -- questions or comments or concerns about correctional officers. And so I put it there, and I know there's probably going to be some more discussion.

Moving further down under I guess the next page, number three, that's just -- and this is the section about skilled support, and I know that the skilled support -- there was a subgroup that worked on skilled support, and they have a lot of stuff -- a lot of information to share with us today.

I just made these changes based on what we did in our last meeting. It has nothing to do with anything that the subgroup -- it worked on. Just made these changes based on -- for instance, there was an -- under the established services to be provided, we wanted to add a couple things, and that was another subgroup that worked on that. So I put some placeholders in there. So those are just going to

change.

Into C, the definitions in our last meeting, there were suggestions for definitions, so we added some. They are based on NFPA, where we pulled most of them from before. In the -- under Emergency Service Organization, we tried to clarify there some more about the law enforcement, some more definitions. And page 6, just clarify the incident safety officer as being somebody on-scene to differentiate from safety officer or health and safety officer.

The definition for law enforcement that I'm sure we want to change, but again, just getting something in there because we weren't clear about what we meant by law enforcement before. Added risk/benefit analysis as a definition. A placeholder on page 7 for the skilled support, workers and skilled support organizations, because, again, we've got a group working on that. And then placeholders for the vulnerability assessment. And as I mentioned, we added a definition for the workplace emergency response team.

Any questions so far on any of that? I could talk faster.

MR. FONTENOT: Bill I have -- you want to go through the whole document and then come back and cover them, or cover them as you get to them?

MR. HAMILTON: Cover these changes? Cover what I changed?

MR. FONTENOT: Yes. Some --

MR. HAMILTON: It's not -- I'm just going through what I changed, and then I -- it's going to be up to Lamont and Rick on how we want to proceed with that I think. So it's -- I mean it's all up for discussion by everybody. I just -- this is just stuff I put in here based on what you guys said last time. So --

MR. INGRAM: Yeah, are these -- Kenn, I'll ask you. Do you think we can go through this as we move through the document and through your -- and cover your suggestions then?

MR. FONTENOT: Whatever is most appropriate.

MR. INGRAM: We're not really asking to -- and Sarah can poke me if I'm not correct, but I don't think we're actually agreeing to these changes right now. We're just going to be going through them. We're going

to go through the document anyway, so if it would work, let's do that naturally.

MR. FONTENOT: I didn't be down there and come back and cover the stuff he just covered, but --

MR. INGRAM: Yeah.

MR. FONTENOT: But if it's more prudent to go through the whole thing, we'll do it and come back.

MR. INGRAM: Yeah, if you don't mind, if that --

(Discussion off-mic.)

MR. INGRAM: Yeah, and identify yourself, Kenn, first.

MR. FONTENOT: This is Kenn Fontenot. I was just asking if it would be more prudent to go over the -- as the changes come up or just go through the whole document and then come back and discuss it. That was my question.

MR. INGRAM: Yeah, and my response is I believe we're going to be going through the entire document anyway, so if we can just bear with it for right now, Bill did his best to make these corrections or changes, and we'll just address each one of your

suggestions as we go if that's all right with you. And we have a thumbs-up. This is Rick by the way.

MR. HAMILTON: Okay. So on page 8 under D, that's I guess pretty much the first place where we started using -- going beyond the generic term "responder" because we changed to "skilled support workers," so I just had to throw in "skilled support worker," and then clarify that it also included the skilled support organizations.

Down to E, there's placeholders for community risk assessment and vulnerability assessment, and on page 10, bottom of page 10, which is F2, it's where I moved the thing we have in the beginning for -- you know, the responder after making a risk/benefit determination decides to make a rescue of a person in imminent peril, you had suggested we move it from the scope and paragraph, and so I'm -- and suggested putting it in risk management, so this is where it is.

I did pull in something -- I looked for other examples that we may have had in OSHA for something like this, and the one thing I found, as you can see in the note, was in bloodborne pathogens. And the example

there pretty much was a police officer who in an effort of apprehending a criminal, the criminal -- suspect, let me be more politically correct -- is bleeding or has bodily fluids or whatever, the officer does not have the opportunity to put on gloves or anything before -- you know, while they're trying to make the arrest.

But once they make the arrest, then they have the opportunity to put on the gloves. And so that's the -- where there's an exclusion in the bloodborne pathogens as an example, but it also goes onto note that it's not -- it's something that needs to be -- that if it's beyond that, if the officer continues to not use gloves and is -- and then becomes infected through further contact, then there might be an issue.

And so it needs to be made on a case-by-case basis. We're trying to, I guess, look at eliminating any potential loophole that may be used by employers if a responder makes a decision to forego their PPE or SCBA or what have you. So it moved from there, and that's the explanation for that.

We still keep the -- still kept the note

because it's an unusual -- we're looking at it as an unusual situation, they risk a lot to save a lot.

MR. INGRAM: Just to clarify, that's the footnote number three on page 11, right?

MR. HAMILTON: Yes.

MR. INGRAM: Okay.

MR. HAMILTON: But does it codify it? Is that what you're saying?

MR. INGRAM: No, I just wanted to make sure that we're talking about the --

MR. HAMILTON: Oh, yes. I'm sorry, yeah. Well, I'm looking at the footnote. I'm sorry. Yeah, I didn't clarify that. I kept it in the -- that it's in the footnote, but that's the intent that we wanted to keep that. And that's just -- at this point just as a reminder. It doesn't -- you know, in -- if this were to go to final reg text, it wouldn't -- probably not be that way as written. I'm darn sure it wouldn't. Sarah's looking at me like, yeah, it's not going to be like that. But it just is a reminder for us that it is that unusual circumstance.

Moving onto page 14, that's just -- it's the

-- it was already covered -- there's a lot of red on there, but it's red because I couldn't just leave "the ESO shall" at the entry to -- at number eight because some of them apply to regular emergencies, service organizations, and they all apply to regular service -- regular emergency service organizations, but only some of them apply to skilled support.

And so this clarifies in here in the text what is already -- what we already say up in B -- in B3, where it says what sections apply to skilled support. This just makes it obvious that if you go to this section and are reading it, which pieces of it currently would apply. That being said, when we hear from the group that -- the subgroup that worked on skilled support, this may all go out the window. But again, I wrote -- I made these changes based on the discussions at the last meeting to reflect that.

And let's see if there's anything else good. Anything else really is -- oh, let's see, there's one more thing. The only other thing -- other substantial change really is on page 20, on the bottom of page 20, we had talked about -- and that's the -- we have -- as

a group, we have not talked about it. It did not come up in the last meeting, but reading through, I realized there was another type of apparatus where people may -- where responders may be standing, and we need to find a way to secure them. Because earlier up we say they need to be seated and belted. Like I said, you guys haven't gotten to that as part of your discussion.

I just added it in here because it was an oversight when we originally drafted this. We took into account, you know, other types of unusual situations, but there is the -- some of the brush-type apparatus where they may be standing or not have a seat and do a pump-and-roll operation. They need to -- we need to have a way of securing without saying they have to be seated and belted. So that was an oversight on our part. I added it in there, and left it in there with a note that I goofed up, and it's in there now.

All right. That's all I have.

MS. SHORTALL: At this time I'd like to enter into the record as Exhibit Number 3 the December 2nd, 2015 draft -- excuse me -- Emergency Responder Preparedness Program Standard with track change, edits

responding to subcommittee member comments from the September 9, 2015 meeting.

MR. INGRAM: Just to respond to Kenn Fontenot, this is still considered a draft, which is up for changes during our meeting today.

Okay. At this time, we'll hear from our subgroups that we established at our September 9th meeting. There's three subgroups, and I'm going to just -- before we start, I'll just paraphrase the duties of each subgroup. And this is paraphrased. Subgroup one, where there is a transition point from an emergency incident to a long-term recovery operation and therefore a transition from compliance for this rule to other existing rules -- where is the transition point? My apologies. And the co-chairs are Pat Morrison and Ken Willette.

So you all want to go ahead and do your report?

MR. WILLETTE: Sure. Thank you, Mr. Chairman. We held a conference call and myself, Pat, Chris Trahan, and I apologize if I'm omitted anybody from the workgroup, were on the call along with OSHA staff and

support. And we followed up the conversation about where is the transitional point from an emergency incident to a non-emergency incident and trying to identify what are some of the metrics that you can use to quantify that so that as we go forward with the regulation, there would be a good benchmark where we go from emergency response activities to non-emergency response activities.

And there was a pretty active dialogue and a lot of examples given of incidents where there was a threat, but there was still personnel operating a vacuum truck or doing some other kind of cleanup operation as opposed to an incident where the threat had been stabilized and the workers who were there were working under the direction of a non-emergency contractor.

And there also was considerable discussion about for those workers at the post-emergency event, their ability to have the proper training equipment and to work independently of the emergency resources, because that's a pretty substantial benchmark. If the contractor still needs emergency services to support

their operation to provide either monitoring, necessary personal protective equipment, standby services or similar activities, then it raises -- it begs the question: Is it truly a non-emergency event at that point?

It was the consensus of the group that if the post-emergency event resources could not operate independently of emergency resources, then an emergency event was still underway. Anybody working in that event would be under the incident commander, working under an incident management system, there would be an incident action plan and a safety plan in place and the prerequisite that they have the proper training, equipment and resources to work in what could be an IDLH environment that may occur with little or no warning.

So after that discussion and providing some of those illustrations that appears in our communication back to the OSHA team, we offer a draft statement in response to the question. And that is post-emergency response activity begins when the incident commander of the emergency incident terminates command, releases the

scene to a responsible party.

The responsible party must be able to provide the required resources, including trained and properly equipped personnel for the risk presented without relying on the presence of emergency response resources, i.e., the post-emergency resources must be self-supporting. So that's our submission to the board.

MR. INGRAM: Are there any comments? Any further comments? At this time I would entertain a motion to approve the report from subgroup one.

MR. FONTENOT: Motion.

MR. INGRAM: All right. Second?

PARTICIPANT: Second.

MR. INGRAM: All agreed?

(Chorus of ayes.)

MR. INGRAM: Any opposed? Okay. Thank you.

MS. SHORTALL: At this time I would like to enter the record as Exhibit Number 4 then the subgroup one report approved at the 12/8/15 meeting as Exhibit 4.

MR. BYRD: Okay. At this time, I'd like to

introduce our second subgroup. This subgroup was formed to develop a paragraph to consolidate, clarify, and delineate skilled support ESO obligations under the rule and draft regulatory text to include as part of the standard.

The subgroup members are Spencer Schwegler as chair, Chris Trahan, Matt Tobia, Kathy Robinson, Jim Brinkley and victor Stagnaro.

MS. TRAHAN: Chris Trahan. Just to clarify that Chris Treml is the person on the subgroup -- on that subgroup, not Chris Trahan.

MR. BYRD: Oh, okay. I'm sorry. In my correction, I corrected the wrong place. Okay. So it's Chris Treml. I apologize.

MS. TRAHAN: And I have a question, before I report, for Sarah. This subgroup met two times, and I wasn't allowed to be in those meetings from what I understood from our first meeting.

MS. SHORTALL: Because you were the alternate?

MS. TRAHAN: I am the alternate to Spencer Schwegler on this committee. So is it possible for future workgroup meetings for -- if there are more than

one person from an entity, to allow the second person to listen only?

MS. SHORTALL: That would be a question for Andy. It's not a legal call as how the agents would like to handle it.

MR. LEVINSON: Sure. I think listening only would be absolutely fine I think as long as each organization has one speaking representative. That keeps the balance.

MS. TRAHAN: Okay, thank you, Andy. I'm -- because I'm going to report out on the activities of this workgroup, but I wasn't able to listen in on it as far as I knew. So in the future, if this comes in again, it will be a little easier.

So the subgroup took a look at the draft as written that identified the various portions of the draft standard that applied to skilled support personnel. The determination was made to instead of following this format and having a skilled support employer be required to really parse through a standard and try to figure out throughout -- sprinkled throughout what applies to that employer and what

doesn't that the workgroup took the approach of creating a separate section that would apply to skilled support employers.

I'm using skilled support employers versus skilled ESOs or how it was originally defined because typically the employers who employ skilled support personnel would not recognize themselves as an ESO, as an emergency service organization.

So with that, the subgroup created a couple of definitions that I'll go through in a minute that talks about the workers affected and the employers affected. The workgroup chose to organize the requirements into three paragraphs. The three paragraphs include skilled support, employers' general requirements, training and personal protective equipment, and, third, training.

One of the highlights, I think, in the training section is that their recommendations include training that be offered and made mandatory pre-incident for those skilled support employers who would participate in an emergency response, and the basis of that training is based on training programs that are widely available throughout the nation

currently through OSHA training institute education centers and outreach trainers who are qualified to deliver this training now.

So it's a system that was put in place between the building trades and OSHA after 9/11 to help train, in particular, construction workers who may be called to respond to disasters, and that system is fully operational and in place with at least 5,000 trainers qualified to deliver the training now around the country. So that was thought to be the best way to incorporate the training requirements in this draft.

So I mentioned that there was a couple of definitions that the workgroup worked on. One -- and now I'm referring to the document that you have that at the top says, "Prepared by the skilled support subgroup." So the definitions are skilled support employer, so the employer who has a primary function other than providing an emergency service, but who designates one or more employees to provide a service at the scene of an emergency incident.

Examples include but are not limited to employers who provide cranes, tow trucks, construction

equipment and utility service, water, gas, electric, public health employers, EMS and medical personnel, et cetera.

The second definition that's been drafted by the work group is for skilled support responders. So this would be the workers, and the definition is an employee of a skilled support employer who is skilled in the operation of certain equipment such as the ones mentioned above who is needed temporarily to perform emergency support work that cannot reasonably be performed in a timely fashion by an ESO responder or -- and who will or may be exposed to hazards at an emergency incident scene.

So those are the crux of the two definitions that were added by the workgroup. And as I mentioned before the workgroup went onto organize the requirements on skilled support employers as general requirements on those employers, personal, protective and training. I won't go through the specifics of this language. I'm not going to read it to you. But it should be pretty self-explanatory, and I think it's a good start in the right direction on addressing the

issues.

So with that, I can conclude this report if the chairs wish, or I could answer questions about it perhaps or concerns.

MR. BYRD: Okay. Are there any questions, comments or discussion about this workgroup report?

MR. WILLETTE: Ken Willette with a question on the definitions and that identifies EMS and medical personnel under the definition of skilled support employer: How did you envision those personnel meeting the skilled support and not the emergency responder definition?

MS. TRAHAN: I would like to defer to the woman next to me because I think this is her issue. Thank you.

MS. ROBINSON: We actually -- Kathy Robinson. We actually discussed some ongoing medical support functions that might not -- that would be in addition to the emergency response, and we thought that those individuals would fit into both categories, actually, that there might be some occupational support, there might be in a large-scale incident some medical care

teams, those sorts of things. But we did struggle with and did not resolve putting them in the same sentence with utility workers. So I think it was something that we were in agreement would come back to this group for discussion. But it was really beyond the emergency response phase and more in a support type of venue.

MR. WILLETTE: Thank you.

MR. LEVINSON: To -- just to clarify, so what you really mean are medical personnel who are doing medical monitoring of emergency responders during rehabilitation at a longstanding --

MS. ROBINSON: That would be reasonable.

MR. LEVINSON: Okay. And you're not to -- and again, to put a finer point on it, are you thinking that emergency medical service providers who do transport only, is that something that you think is a skilled support, or is that something that you think is emergency response?

MS. ROBINSON: I think it could be both.

MR. LEVINSON: How would you like the agency to look at it? And I'm asking because we would have to figure out is that function something that would be

covered by skilled support, or would a different emergency response provision in this draft regulation apply. So how would the agency know when somebody was under this provision and when it was under a different provision? And not to put you on the spot because this is a challenging question, but that's the question that we would need to answer and provide clarity to the public is: When does this provision apply and for which specific services?

So for example, I could envision the people who are working outside the hazard area doing medical monitoring for rehab of emergency responders being a skilled support type function. The transport people might have a harder time finding them under skilled support because of the expectation that they provide some higher level of emergency response or medical intervention. And that's something I think would be worth exploring further.

MS. ROBINSON: No, I agree. Your point is valid. If the -- I guess the question would be if those categories fell under emergency service organizations and the previous report out was that

here's the line of when it -- the incident changes from emergency support to ongoing support, does that exclude anybody that falls into the previous categories from ongoing responsibilities as the roles would apply? And if your thoughts about that would be that just because there's -- we've defined a line in between those functions that the individuals would still be required to comply with the requirements, they probably don't need to be listed in the -- under the skilled support employer because they've already been covered.

So my question to you would be: Would they be excluded at the time that the -- from I guess Exhibit 4 where the post-emergency response operation transitions from an emergency response to rehab, cleanup, whatever it is that you want to call it?

MS. TRAHAN: And this is Chris Trahan. My understanding is at that point in time the standard would no longer apply because the first question -- the first workgroup undertook the question of what is the scope of the standard. Once the incident is declared over and handed over to the non-ESO employer from the OSHA perspective, then this standard would not apply

and just regular OSHA regulations would apply. Does that work?

MR. LEVINSON: Yeah, that's my understanding.

MR. MORRISON: Pat Morrison. That's what we did discuss in the first workgroup with that, that we thought that when that emergency response ended and there was additional services, that that would be applied under another OSHA regulation. We tried to clarify that, and there was a lot of discussion in that, that that was where that crossover I believe was --

MS. ROBINSON: And we didn't have that clarification in this particular discussion. So I would be okay removing the reference to health personnel as long as there's an understanding that other regulations would kick in.

MR. BYRD: Okay. Any other comments, thoughts?

MS. ROBINSON: That discussion would have been helpful to the group.

MR. FONTENOT: Kenn Fontenot. On the definition of skilled support responder, that was one

of the questions I had earlier when Mr. Bill was talking about the changes on page two, the second group, it says "The change would be skilled support responder to skilled support worker," and in this definition we're using "skilled support responder." So for clarity, maybe we should consider changing it at this point.

MR. BYRD: Okay. Did we get that? Okay. Are there any other questions, comments?

MR. LEVINSON: Well, is there a preference for skilled support worker or skilled support responder?

MR. WARREN: I think worker -- this is Bill Warren from Arizona. I think worker expands it a little more. Responder seems to be just -- you know, just the local emergency -- so worker would include the construction workers, it would put all those --

PARTICIPANT: Use the mic.

MR. WARREN: I think that that would be a part of that. So I think worker works best at this point. Just my opinion.

MS. TRAHAN: This is Chris Trahan. I think it's fine to change it to "worker." I prefer the term.

If there's not objection, perhaps we should just consider the changes to be made in this report and use that terminology.

MR. BYRD: Okay. Kathy?

MS. ROBINSON: I was just going to say that I think that the group understands that OSHA could create an exhaustive list of personnel that would fall under the standard. And the intent was really to make sure that those groups that should recognize that this applies to them does.

MR. WILLETTE: Ken Willette. And I think using the term "worker" makes a lot of sense. And one of the primary reasons is from a thematic point of view, responder should be the highest level of training, preparation and preparedness. And if we're consistent with making that somebody who is hands-on, operationally engaged with the expectation of the highest level of training, that sets a benchmark.

When we bring down to the worker category, it is somebody who is there as a support worker, and there should be in the regulation -- and from a concept of communicating it to the external stakeholders, there

should be a clear strategy of defining what a responder is versus a support worker. And I think beginning to introduce that term as early as possible makes a lot of sense.

It might address some of those questions that came up about the role of EMS and medical personnel and others and where is that dividing line. So I would be supportive of using the term "skilled support worker" as opposed to "skilled support responder."

MR. BYRD: Okay. Thank you.

MR. INGRAM: Yeah, just I think you make a fine point. My question back to the group would be: Do we need to have an additional definition for worker versus responder?

MS. TRAHAN: And Chris Trahan. I don't think so. I think that just using the terminology when it comes to skilled support or skilled support worker is appropriate, and we have a definition. Just simply swap out responder for worker as it relates to skilled support is something I'm very comfortable with. I don't know if anybody else on the workgroup would disagree, but if you do, perhaps we could hear that.

MR. BYRD: Any other -- everybody okay with that?

MS. TRAHAN: Everyone's nodding their head in agreement.

MR. BYRD: Everbody's okay with that? Okay. Are there any other questions or comments about the report?

MR. TOBIA: Just a -- this is Matt Tobia. Just a question. The last sentence in parentheses on the second definition just refers to state plans. States can address volunteers and their state regulations. I would assume you're referring to untrained individuals who ask -- who raise their hand and ask to assist at an incident. Is that the intent of that parenthetical?

MS. TRAHAN: I would defer to people who were in this conversation.

MR. WARREN: No, I would -- this is Bill Warren. We have a lot of volunteer fire departments that are unpaid, and so I think that that would cover those, too. The state plans to address those volunteers either usually in their worker's comp and

their definition of what an employee is. So for example, as in Arizona, a firefighter volunteer is considered an employee. So I looked at that as covering those employees.

MR. TOBIA: And -- this is Matt Tobia again. Bill, you bring up a good point, but across the United States, there is a wide divergence within the legal community about the definition of whether or not OSHA applies to volunteer firefighters or not, and I think at least for me personally, I'm trying to cast as broad a net as possible to ensure that their safety is secured given that 70 percent of them -- 70 percent of our fatalities are volunteer firefighters.

And I have had the personal experience of having, unfortunately, volunteer fire departments seek legal interpretation that OSHA does not, in fact, apply to them because of the word "employer," that employer and employees refers to some employment -- you know, some payment of -- for services rendered as opposed to workers. So I'm just -- I'm trying to avoid, honestly, an attempt for there to be a loophole that would otherwise exclude individuals who should be covered

under this from being included.

MR. WARREN: Oh, I concur. What I was identifying is that some of the states have actually defined those volunteers as employees.

MR. TOBIA: Could we extend that into this document? In other words, ensuring that rather than lending it open for interpretation on a state-by-state basis, could we not at a federal OSHA level define that?

MR. LEVINSON: So let me give you an easy answer. No. We can only cover the folks that we have authority and jurisdiction on as the states adopt their own equivalent laws. They then have the ability to adopt and adjust based on their state labor laws. So it really is in the state plan, states -- going to be up to the individual states about how they address the volunteers and those concerns. And each state has different thresholds for how much compensation counts as enough. So it could be a life insurance policy, a gym membership and $10 in gas money per run in some states could be enough. It's a state-by-state decision.

MR. TOBIA: We could, though, include it in the federal OSHA standard, though, right?

MR. LEVINSON: You could make a recommendation for what you think states should do, but it would be up to the individual states.

MR. BYRD: Okay. If I could get Lisa and then Chris.

MS. DELANEY: Yeah, this is Lisa Delaney. I also was supportive of pulling out and having a separate section that's dedicated to this skilled support employer. I found it very confusing to try to pick through the standard, the current draft to figure out which is -- what's applicable to the skilled support employees or workers. So I'm -- I think I really appreciated this change.

MR. BYRD: Okay. And Chris Trahan.

MS. TRAHAN: I think that the conversation of coverage of volunteer firefighters is kind of misplaced here when we're talking about skilled support personnel.

I think that I would like to make a recommendation that the committee consider the

inclusion of volunteers who are skilled support personnel under the scope of this standard. And, for example, if an incident occurs and somebody who understands how to cut steel if it's needed in the response to that incident is driving by with his equipment and stops and offers his support to the emergency service organization, that that worker, while he's volunteering, should be given some coverage under this OSHA standard or some consideration of protection under this OSHA standard perhaps by the emergency service organization. I'm not sure how easy that is to capture in a regulation, but I just wanted to throw that out there.

MR. BYRD: Okay.

MR. TOBIA: This is Matt Tobia. I don't disagree with Chris with regard to the broader issue of volunteers. I do think, though, that I would strongly encourage that we provide guidance to states who have their own state plan about the intent of covering volunteer firefighters so that at a minimum there is guidance. Although we cannot dictate what they do, I think clarity is the key about what our intent was on a

federal level to be able to provide them with guidance.

Ultimately you're right. They will need to make their own determinations about defining that. But at least at a federal OSHA level, that there would be some guidance.

MR. LEVINSON: Let me ask a clarifying question to the committee. This envisions skilled support employers who plan on responding and who can in advance train their folks, procure PPE, and I think this volunteer issue that you raise gets to the we didn't have a plan in place for a person with a particular skillset, so we opened the phone book or, you know, the current version of a phone book, and you go find somebody who can do that in a pinch. And how does that person -- is that a volunteer? How does that function?

MS. TRAHAN: This is Chris Trahan. No, that's not a volunteer. That's if the ESO fails to preplan and fails to arrange for the necessary function. So that's not a volunteer; that's a failure of some sort. What a volunteer would be would be an individual volunteering at a scene, not an ESO realizing that I

should have had a tow truck company prearranged to support us and I didn't. That tow truck company is not then a volunteer; they're being paid for their work.

MR. LEVINSON: What's the expectation for training equipment or other -- how do you address the we didn't plan for that, but we need somebody at a moment? Is that covered here, or is that something that we still need to figure out how to accomplish?

MR. WILLETTE: Ken Willette. In this discussion of volunteers, regarding the volunteer fire service, the job is inherently dangerous regardless of what level you're performing it at. And for clarity and giving guidance to the entire nation, if we approach firefighting as that level of response and requirement with the ability of the local jurisdiction to comply with the regulation, then I think we'll address the volunteers. And knowing that there's the overarching guidance of the relationship between state plans and federal OSHA, then that can be worked out in perhaps an advisory as Matt suggested.

But to expand the discussion to look at those on-scene volunteers who might require just-in-time

training or some other approach to be able to meet the requirements, I think we're straying from the intent. And this is really focused on the organizations and what is their responsibility to the individual. These individuals who self-deploy, self-report, I think it's unreasonable to expect the organization that can be held responsible to provide just-in-time training and to rely on them in the same manner as we're defining here.

So my concern is I think we're going into an area that doesn't fit nicely into the regulation and could be a real challenge.

MS. TRAHAN: May I respond? Chris Trahan. I agree with you, and I think that it's worthy -- I think it's worth noting this concern, but I don't think it fits nicely into this regulation, because this regulation is about preplanning.

To go to Andy's question of what if the ESO didn't preplan but then at the last minute calls a skilled support employer to assist, I believe that the group tried to capture some of that with the understanding that that may happen even though that's

not the most desired situation. In the training section, if you look towards the end of the draft paragraph, the recommended paragraph on training, the -- it looks as though the group attempted to capture this is in paragraphs 1-4 and 1-5 to -- with an understanding that this might happen, but that you can't just waive all training requirements.

Do you -- I'm just asking if anyone who was on these calls, if the group thinks this is an accurate description of these paragraphs or not. Am I missing something?

MR. LEVINSON: The part that I'm just having trouble with, so my understanding of emergency response is that there are still times where there's just-in-time training. And how do you accomplish that under this, or is this group saying that there should not be just-in-time training and that you should not allow anybody to provide skilled support response in any capacity until and unless they've completed seven and a half hours of training?

MR. INGRAM: Can I comment on that? So I was not part of this discussion either, but it does --

paragraph 1-4 states that may not provide skilled support responders and ESOs may not deploy SSRs until they have received site-specific briefing informing them of specific hazards. And I think that's probably -- a site-specific briefing would be much different from the seven and a half hours.

But then when we get down to number five, it says training may not be waived because of the emergency phase of an incident. So I think -- I have to agree with Andy. I would think that there are some times, whether it's pre-planned or not. You can't possibly -- you want to try to understand all the possible scenarios, but I would assume that it's impossible at times having been in emergency response myself from time to time.

So the briefing might be all you can do if it's a life-and-death situation, and you wouldn't want to, you know, go back and do the seven and a half hour training if it's a life and death situation. So that would be my point. I don't know how other people feel about that.

MR. INGRAM: Yeah, I think Kenn has a --

MR. FONTENOT: This is Kenn Fontenot. I'm in agreement with Rick on that last statement simply because it happened to me before, and I did just-in-time training, enough to, in my mind, make sure that the person doing that skill service was covered, knew the outcome of -- potential outcome of contamination of it, and then asked if he was still willing to perform it. And you're right. So that's part of the real world that we deal in sometimes, that if you don't do this, you wait seven and a half hours or so, then it's really gotten away from you.

So -- the other comment I had was billing and what Chief Matt and Mr. Ken were talking about, the volunteer portion of it, and I do represent a large segment of the volunteers in the country, is that perhaps we should define an ESR, which we don't have a definition for that I've noticed yet and just call them emergency service responder. And then we could make the -- say, hey, it doesn't matter if you're career or if you're a volunteer, you're considered an ESR. And that kind of helps us with the guidelines there at the state level saying that it doesn't matter if you're an

employee-employer relationship, you're still considered an ESR, and you need to follow these guidelines, and I think it -- to me it would help clean up a whole lot of language in a lot of ways that now we know what they are, what we are or what -- so I don't know. You seem to be listening over there.

MR. WARREN: Yes. Bill Warren. No, I concur with that. I guess my only bigger concern is that as you take a look at that for the small fire departments that are mostly all volunteers, the expense would be one of the concerns that they would have for new equipment and things like that.

For example, a young fire department up on northern Arizona gets most of their equipment from used fire departments or that they get from other fire departments that's used. And their total operating budget is $26,000 a year. So that's -- with all their different additional requirements, I'm concerned that some of them may not be able to meet that as we defined it specifically.

MR. FONTINOT: The -- again, this is Kenn. And where I'm from, a 26,000 budget makes you a rich

department. My budget when I was chief was 3,500. I'm not trying to outpour you --

MR. WARREN: There were some -- I'm just saying that that is a limited amount of funding --

MR. FONTINOT: Agreed.

MR. WARREN: -- to completely outfit both medically and equipment-wise. And I just want to make sure that we don't put those folks completely out of business.

MR. FONTINOT: One way or the other, they've got to be brought into line with having to follow some sort of standard or guideline.

MR. WARREN: And we agree --

MR. FONTINOT: And having a definition of what an ESR is, a person would be called, I think it helps define it in a lot of ways. And again, it goes back to the -- having from the charges of the committee to my understanding is right as having the ability to decide at what level that they're going to actual implement response, kind of helps with a lot of issues.

MR. WARREN: I agree. But I do concur maybe the definition would be helpful.

MR. LEVINSON: To circle back to the training piece, let me put out for discussion one alternate approach might be a provision that allows for some just-in-time training so that people can work at a disaster site or an emergency response and then provide some additional security for that person so that you could say you can provide just-in-time training and then perhaps and emergency responder's shadow or escort while they're in the hazard area.

MR. FONTINOT: Under direct supervision.

MR. LEVINSON: Right. So that there's somebody who is fully trained to help make sure that that person is safe on the disaster side, but allow more flexibility if the need arises.

MS. TRAHAN: Chris Trahan. I think that this should go back to the workgroup for discussion, the desire to identify what just-in-time is -- would be needed. What I'm concerned with is that how do you necessarily just-in-time training on the respirator that's needed or the personal protective equipment that's needed or the incident command system that they have to understand and follow.

As a skilled support worker, that's not part of the normal vernacular, and the risks are relatively high in an emergency situation. So rather than, I think, belabor the point, would it be appropriate for the workgroup to consider that question and perhaps make a recommendation?

MR. STAGNARO: This is Victor Stagnaro. As part of the group, it was the intent of the group to just provide that level of training so they would have -- so that a worker would have a general idea of what kind of emergency they might be responding to, the special equipment they might be required to wear. It wasn't the intent to not provide that just-in-time training but to provide an overall requirement as an organization.

If I have an organization that's going to provide emergency services in a support role, then those personnel that will be providing that skill will have to have certain levels of training in order to be able to function. That doesn't mean that once they get on the scene, which is actually the intent, where you would get a briefing once you've arrived on the scene,

it was the intent to provide that briefing to say, okay, these are the special skills that you're going to need to be required and if there's just some just-in-time training that needs to be provided there, at least have a basic understanding of emergency operations, personal protective equipment, respiratory equipment and those kinds of things.

MS. TRAHAN: Now if I understand you -- Chris Trahan. If I understand you correctly, you're saying that in addition to the pre-incident training, the on-site briefing has to occur, and that's how I read what's written here.

MR. STAGNARO: That's correct. It was the intent of the group to say everybody who arrives on the scene to provide emergency services support would have a basic level of training. It was the -- I thought of the group that at a minimum of seven and a half hours should be required in order for those personnel to get on the scene, and then there would be a briefing by an incident commander or an appropriate personnel to provide details of what's going to be asked of that person.

MS. TRAHAN: Thank you. And so what I'm hearing from this larger group is that that's unacceptable and that we want to know what just-in-time training can be substituted for this. So what I'm suggesting is that the workgroup consider that question and then come back with a recommendation.

MR. LEVINSON: Right. And let me clarify my point. I don't think that -- this is Andy. I don't think that that's unacceptable. I think that that is what should happen most of the time, but there is also a recognition that there are subset of circumstances where people are not going to have planned on responding when they woke up that day and are not going to be part of an organization that planned on responding. And how do we address skilled support workers who are not part of a planned response so that they can operate safely at these incidents as well.

MR. TOBIA: This is Matt Tobia. I would -- just for clarification, I agree with the recommendation as it's provided here for organizations that intend to function as a skilled support organization.

In addition, I would offer that the --

ultimately the jurisdiction having authority or the incident commander would be responsible for ensuring the safety of skilled support workers called to a scene on a one-off incident that they might not otherwise ever be called to where the briefing would need to -- there would need to be language that extends the responsibility of ensuring the safety of those individuals to the organization that called them to the scene.

So for example, if there was a one-in-a-lifetime incident where a particular crane was needed on a scene, a company that wasn't normally involved in emergency response support was in possession of that crane and could come to the scene, that the jurisdiction that called them to the scene would be responsible for ensuring the safety of their personnel while they were operating on the scene of that emergency.

MR. MORRISON: This is Pat Morrison. I agree that's usually the scenario -- exactly the scenario that takes place because it's usually sometimes once maybe in a decade, once in five years, once in that you

do need somebody. But the incident commander has requested that support and going on the scene there's -- that's exactly what they're used for.

A lot of times, just-in-time training is usually -- if it's on a scene, it's usually a long-term event. I mean it's an event that's going on from Katrina or from Hurricane Sandy. Those are -- that we're asking workers to come in and assist that we have time to do the just-in-time training. If you don't have time to do it, then it's not just-in-time training. It's just that you are just asking for those services.

And I do think -- and I agree, I think, with what Andy was saying earlier, too, that I think that there is that -- there is that moment that are you are going to have to call somebody that you did not have a prearranged situation where they knew everything, but they are under the incident command, so they will be under that safety matrix that is supplied for everybody on that scene. It doesn't matter who they are, but anybody who shows up.

MR. INGRAM: I had one other comment, and I

agree with everything that has been said. I agree with the text as it's written. And my only point was I also agree that we need to have a provision that allows for an unusual circumstance, and it would be the exception rather than the rule when you would have someone who had not been through the training.

But also to Andy's point about being accompanied by a trained responder, that might be something that we would write into the language. So I also agree with Chris. I think this is a broader -- it should be taken back to the group and discussed again and come to a consensus view.

MS. TRAHAN: Chris Trahan. The -- so can I take back the charge that this workgroup would like the subgroup number two to create or try to create a provision that allows for exceptional -- in exceptional circumstances for just-in-time training for skilled support workers? Should -- is that the request?

MR. BYRD: Could you restate that? I'm not exactly clear as to what you asked.

MS. TRAHAN: Okay. I'll restate what I've written down, that the workgroup has asked the

subcommittee -- what are we, a subcommittee or work group?

PARTICIPANT: Subcommittee.

MS. TRAHAN: The subcommittee --

MS. SHORTALL: Subgroup.

MR. BYRD: Subgroup.

MS. TRAHAN: The subgroup is asking workgroup number two to --

MS. SHORTALL: Sorry, subcommittee.

MS. TRAHAN: What?

MR. BYRD: The subcommittee is asking the workgroup --

MS. TRAHAN: Sub-workgroup?

MS. SHORTALL: I think I could maybe cut quicker to the chase.

MS. TRAHAN: Please.

MS. SHORTALL: I think when these subgroups were created, there was anticipation that they would continue to keep meeting and addressing issues until the subgroup and the subcommittee as a whole decided there was nothing more for them to address. So I do think it would be appropriate for the subgroup to

continue meeting. You've heard comments, to see how you want to address them and then continue to come back. Each meeting that you do in which you give a report we will want to have those reports approved so we can enter them into the record. We'll have an ongoing history of what the subgroup had done.

MR. BYRD: Thank you, Sarah.

MR. TRAHAN: Okay. So the -- just to -- Chris. This is Chris Trahan. To create a provision that allows in exceptional circumstances for just-in-time training for skilled support workers. That's the ask here is -- yes?

MR. STAGNARO: Chris, if I may, this is Victor Stagnaro. I would include address any time a non-planned emergency services organization responds to the scene. So there may be situations in which just-in-time training will be required or there might be situations in which an escort or a member of the emergency services team would accompany the organization representative. I mean I think there's lots of -- so I think the whole group should come back and address non-planned emergency services

organizations response, in which case they would not have had the seven and a half hours training. It would have been a group that had not planned on responding to an emergency incident. Would that cover what you're looking for?

MS. TRAHAN: Yes.

MR. TOBIA: If I could also -- this is Matt Tobia. I would also offer that skilled support employers have an obligation not to accept a mission for which their personnel have not been trained if they -- they need to prospectively make a decision whether they are or are not going to accept that mission. It may be you call and we say, no, we can't provide that service because our personnel are not trained to this minimum standard.

I think the minimum standards are critical so that it provides guidance to support service organizations who intend to play that role to know what do our people have to have. What is the minimum amount of training that our people have to have, and how do we get it? I think that's critical to list that.

I think it's also incumbent to identify that

organizations have a positive or an affirmative responsibility to not accept a mission for which their personnel are not trained, which kind of goes back to the general duty clause, but in that situation -- and I do think -- I agree with Pat, there really is a difference between just-in-time training which may be connected with a campaign incident and a short-term, single operational period incident where we need somebody with a specific set of skills who would be supported.

MR. MORRISON: Pat -- I'm sorry.

MR. BYRD: No. Okay. Go on, Pat.

MR. MORRISON: I just -- the only other thing we have to think about, too, and I do agree that -- I'm glad that Sarah explained that the workgroup can go back, this workgroup. The other -- when you have skilled support showing up on a scene, it's not just that they have the just-in-time training. There's a lot of times that the first responder, the firefighters there working with the skilled support, we don't have the training either if we're operating in a situation where they are coming in with their expertise.

So that's a -- it's a -- and that's exactly what has already happened on a couple of scenes, where the just-in-time training was really -- was for the firefighters also, the crane operators coming in and doing their work that they do, highly skilled. There is a training if they're on their own worksite that workers around that event have to be very, very cautious of.

So it's a double -- there's a double -- for emergency, because we don't do this very often. When we do it, it's -- usually it's an event we need -- it's usually time. It's time-critical. And that's the only reason that we would do this, that -- and we don't have the tools so we have to bring somebody in. But we actually have to have that same sort of understanding that there is an exchange.

So that is -- you're asking for somebody to help you, the incident command has done that, and that incident command is where that interface. So the incident command works with that skilled worker and they go over what is about to happen, and that's on both sides, from the skilled worker and for the

emergency responders.

MR. FONTINOT: And to that point -- this is Kenn. To that point, Chris, perhaps that would define what just-in-time training consists of and bearing in mind that it is time-critical. If you don't have seven and a half hours it's going to be a 20-, 30-minute session sometimes if you really have the need for it. So that -- a definition of what just in time is probably would be very beneficial.

MR. BYRD: This has been a very productive discussion. And at this point, I'd like to give the floor to Bill here. I think he has something to add to this.

MR. HAMILTON: I -- well, I hope so. Bill Hamilton. Just as a skilled support -- the subgroup working on skilled support moves forward, I would just like to remind everybody that on page 3 in paragraph B3 where we did -- as OSHA to try to search through the document and identify the parts of it that apply to skilled support employers and skilled support workers, and it's bits and pieces which all the rest of it, which I understand now that you're interested in

pulling them all and -- but just as a reminder, as you do go forward, for example, under one of -- the fourth bullet said "minimum training" and then you jump back to page -- it's either page 20 -- on page 28, we have the section for use of skilled support workers saying the results of the minimum training --

PARTICIPANT: Fourteen.

MR. HAMILTON: Page 14? So there's -- G8 under page -- does have some training for identifying some of the things that may be needed. So we tried -- understanding you want to pull it all together -- some of it's out there and we continue the discussion -- just as the group moves forward, we could use that list as a place where we've already drafted a little bit of language and try to expand on that. Thank you.

MR. BYRD: Okay. Thank you, Bill.

Are there any other comments concerning this report?

MS. TRAHAN: Just to -- Chris Trahan. Just to bear in mind that the way this is structured, the paragraphs that are pulled out are the requirements on the skilled support employers, that that was the intent

here to make it understandable for what was required of the skilled support employers. What's required of the ESOs is different in how they deal with the need for skilled support personnel. So I think some of this is pertinent, but there's a larger conversation of how the ESO has to function and mandate and control the situation as it pertains to skilled support, which I think is not what was tried -- was necessarily captured here.

To go to Bill's point, this paragraph, is it G8, is very, very good, but it really comes down on the requirements on the ESO, not the skilled support employer as much if I can just kind of put that out there. But I do have notes and we'll bring the charge back to the workgroup at this point and continue on.

MR. LEVINSON: To -- let me just -- this is Andy. Let me clarify. I guess my question that I have is the way that you just framed the issue. I think you're looking at it, Chris, as these are the requirements on skilled support employers who provide skilled support workers to an emergency services organization. But you're saying that there might be

requirements on an emergency services organization who gets a skilled support worker that does not come from a skilled support employer. Like you get a random person, and you're saying that should not be in the skilled support section that you're -- that you've been drafting.

And so the question -- so I guess my question, one, is is that what you're thinking, that there are skilled support workers who might be these volunteers or unplanned people that should not be encompassed in the section that you've just written and then there's got to be another place somewhere that says here's how you deal with these skilled support workers who did not come from an organization that we had a relationship with. They're just random people who drove by and we picked them up for this particular incident.

Or -- and this is one of my concerns is that in saying that we've put all the skilled support stuff in one section, is that where people are going to look for all the skilled support stuff. And so taking this one piece of the skilled support worker who's kind of orphaned from an organization and putting it in the

rest of the document, does that create more problems? Or does that all make sense to everybody the way that I'm kind of framing this issue?

MS. TRAHAN: I think it does make sense. The questions -- and I think questions -- I'm not -- I can't necessarily answer all the questions, but when you -- my understanding as a non-emergency service person or responder is that the incident commander is in charge of the site and the planning is done by the organization who's in charge of emergency services. And my understanding is that these paragraphs relate to those employers who would be arranged to provide skilled support personnel in advance of an incident. Where you get into the muddier issues is what about the one-ups, what about the just-in-time need for those one-ups, and a whole larger issue is what the is the obligation of the ESO to prearrange for skilled support for their future incidents. Those are not part of the -- these three paragraphs and these two definitions, but they need to be considered, and I'd like to -- I think the workgroup should continue to consider these and make recommendations, but I really do view that

these three paragraphs are related to where the ESO has to make these arrangements with the providers of skilled support personnel in advance of an incident. So does that answer your question kind of? No?

MR. LEVINSON: Well, I think there's a bunch of other people that have --

MR. BYRD: Okay. I'll go here, and then --

MS. ROBINSON: No, I'd just like to make a comment. I was just looking back at the edits that Bill had made to the document, and at the time that the subgroup was meeting, the original draft addressed general requirements such as medical requirements and decontamination and training, et cetera, only for ESOs.

And with Bill adding the or skilled support workers into the language, it may -- I'm in support of taking it back to the subgroup, but I think that the issue might be resolved because Bill's already fixed the foundational document to include those sorts of things.

I don't remember getting into the weeds as much on the subgroup calls about whether it was volunteer firefighters or who this definition captured,

but in looking back at that, you know, we seem to be mixing emergency service organizations with skilled support, and I don't think that that was the intent of the subgroup, and the issue might be resolved because of Bill's language and perhaps the suggestion is the subgroup take a look at that to determine if that is true.

MR. WILLETTE: Ken Willette. In listening to the conversation, one thing that strikes me is we started by talking about volunteers, and then we kind of morphed. And it strikes me I don't know that we're talking about volunteers as much as people who self-deploy, people who have not been invited to be on-scene as a responder by an emergency service organization or by a skilled support organization. And that, to me, indicates a relationship outside that organizational boundary.

And as Pat said, under established principles of incident management, if those self-deployed individuals are allowed onto the incident scene, they become the responsibility of the incident commander. And they must provide for their safety in whatever

means are available given the nature of the incident. That's a risk/benefit decision. So if it helps for the purpose of clarification who we're trying to address if we use the term self-deployed, because, again, that goes outside the established organizational boundaries.

To Chris's point, as part of pre-incident planning, an emergency services organization should have identified its skilled support resources and more or less invite them to the dance, if you will, knowing that they meet the requirements and the incident commander can have confidence that they're going to be able operate safely and not be a detriment to the incident.

But when an individual or an agency self-deploys, you don't know the individual, you don't know the level of training and who is responsible for that individual and allowing them onto the incident scene ultimately would be the incident commander through whatever mechanism they set up.

And in the large-scale incidents, they have branches that specifically deal with those types of things, providing for the training and the recruitment

or sending everybody home as the case may be. So I would just offer that for clarification as we look at this one-off and this exception. Is it the self-deployed individual, and how are they going to be addressed as opposed to the term "volunteer"?

MR. BYRD: Okay. And I would think that -- and I agree, you know, with much of what I've heard today and that there is going to be a need for the workgroup to revisit -- actually reconvene and expand the scope of what you were doing based on this conversation.

Because when I go back to your initial -- the initial assignment -- and I'm on -- in terms of where I'm reading from, this is -- the summary of the minutes of the last meeting on page 7, it says, "A second subgroup was formed to develop a paragraph to consolidate, clarify and delineate skilled support ESO obligations under the rule draft regulatory text to include part of the standard."

And I think that's what you all did within that context. And this has -- I agree that this has morphed into something considerably larger to consider

the one-offs and the volunteers. So I would think that, you know, at this point that we would need to ask the workgroup -- subgroup to revisit this within this context if that makes sense.

MR. MORRISON: Just real quick. Yeah, Pat Morrison. I think that -- and we had more discussion on this later, but I do think that the skilled support -- the language needs to be in its own section. I really do think that that -- at the end of the document will have a lot more merit than trying to spread it out throughout the document.

I think most of the time the skilled -- I think the skilled support employers are not going to be the ones that are going to be reading this. It will be the ESO organizations that will realize that they need to have that relationship, and I really do think that that has to be spelled out.

And if there is a way, I don't know how this document is going to be laid out in its final format, but I really do strongly believe that all of those should be tied into that, and that does eliminate, again, we're crossing the volunteers of somebody, a

good Samaritan stopping by saying, hey, listen, I've got this to volunteers, which is the volunteer fire -- which is a big, huge -- you do not want to confuse that.

That will cause a lot of chaos out there I think when this it is coming out there. But I do believe it should be a clean section that really spells it out. And I think for the benefit of this document, it will do more for us in the fire service by doing that.

MR. BYRD: Thanks. Rick?

MR. INGRAM: Yeah, I just wanted to say what we're discussing here will eliminate a lot of future letters of interpretation.

MR. BYRD: Are there any other comments? Okay. Hearing none, I think this has been a very productive, you know, conversation here. How will we go about -- I think we probably need to revisit the charge to the workgroup. Could we draft something up so that it will be clarified as to what they're being asked to do?

MS. SHORTALL: Certainly if the committee --

subcommittee would like to do so. In the meantime, maybe we could just get the -- this current report adopted.

MR. BYRD: Okay. One last ask: Are there any other comments regarding the report? Okay. Hearing none, I'd like to entertain a motion to approve the report from subgroup two.

PARTICIPANT: So moved.

MR. BYRD: Do I have a second?

PARTICIPANT: Second.

MR. BYRD: All in favor?

(Chorus of ayes.)

MR. BYRD: Opposed? Abstain? Okay. Thank you. I think it's probably time for a break. So it's 10:40. That would be, what, 10:55, reconvene 15 minutes?

MS. SHORTALL: Before you go into break, then could I simply just mark it as Exhibit Number 5, Skill Support Subgroup Report approved at the 12/8/15 subcommittee meeting.

MR. BYRD: Thank you.

(A brief recess was taken.)

MR. BYRD: Okay. As we reconvene, I'd like to remind you that the sign-in sheets are on the back table now. Thank you. Okay. Subgroup three, and I don't have my notes in front of me, okay.

MR. INGRAM: So welcome back from break. Great discussion, and I just want to -- before we continue, I just wanted to make a comment. I guess I have the prerogative, don't I, Sarah?

So this was such a great discussion on the subgroup two, really good. And we brought out some points that we needed to bring out, and the better job we do of being outspoken and saying what we think, the better product we're going to have and the fewer letters of interpretation we'll have later. So if we can write this considering those scenarios, unknown variables as we go, it's going to be better for everybody.

And we're going to have a product that we're all going to be proud of and that's going to help protect workers, and that's the whole -- help the employers and protect the workers and communities, and that's the whole purpose of this. But the more

outspoken we are and the more friendly discussion that we have just like we had then, the better. So I just wanted to say that. So compliments to everybody. Compliments to the subgroups, members and to everybody here today. You're doing a great job.

The -- we did form a third subgroup. That was formed to assist OSHA in reviewing the vulnerability assessment program with an eye toward identifying language from NFPA and concepts of community assessments that could be helpful in developing wording for the standard. The online assessment VAP tool was developed jointly by the National Fallen Firefighters Foundation and the United States Fire Administration.

And we have five subgroup members and the chair is Pat Morrison, and the co-chair is Kenn Fontinot. And I believe you all have not had a chance to meet yet, but bear in mind that these folks are on another subcommittee as well. So you can only volunteer for so much, and then we had the Holiday Inn in the mix.

So Pat, did you want to --

MR. MORRISON: Thank you. Pat Morrison, yeah.

Thanks for that --

MR. INGRAM: Backdoor. In Texas, we call it backdoor.

MR. MORRISON: I always appreciate that, yeah, covering for me there, too. We are going to -- we do have the meeting planned. That is January 6th that we just got together. This has got a lot of information in this subgroup, especially with the assessment process, so this is going to take us -- we would like to meet face-to-face. We have everybody in the committee that can except one that we will make sure that we have dialed into our line.

I'll get that meeting notice out. I know that we have -- I'll send -- I'll make sure I do the proper CCs, that we have the OSHA representative on that with us. I know that that has to be part of that. But this is a bigger one. So we're going to be meeting January 6th at the IFF office for that meeting. So that is scheduled. It's on the books and I apologize. We will have something out for the next meeting to discuss.

MS. SHORTALL: As a procedural point, Pat, could you make sure that the co-chairs are apprised of

your meetings as well as Anne Soiza who is the chair of NACOSH. That way they can all remain on top of all the information that comes out. And even in subgroups it does require that we have an OSHA representative at the meeting.

MR. MORRISON: Yeah, I'll make sure I get Bill and Matt on that. I didn't know the NACOSH, the one that you had said, what was that?

MS. SHORTALL: That's Anne Soiza. She is the chair of NACOSH.

MR. MORRISON: That was the one that -- okay. All right. Thanks, Rick.

MR. INGRAM: Okay. So we're going to -- next on the agenda is to review and discuss the risk management plan, facility and equipment preparedness, vehicle preparedness and operation. And I think we'll turn to Bill Hamilton to give us the -- boy, you were surprised, weren't you, Bill? So take us to the right section here is all I'm asking you to do.

MR. HAMILTON: It looks like page 9, section F I think it is. But I think what you're -- we did have a document, the potential topics of discussion, and we --

the first -- we've essentially gone through the -- on that one we've gone through the first three, because those were the -- address the three subgroups, and so if you're -- if you're onto five, paragraph F, risk management plan, there's some questions there if you want to kind of follow along with that or --

MR. INGRAM: You're as prepared as I am for this discussion, so okay. So let's go ahead and start with that question. Thank you, Bill, for allowing me to put you on the spot. So paragraph F, risk management plan is currently drafted. The section on risk management plans and vision is a written document that would become the basis for training, standard operating procedures, response equipment, personal protective clothing and equipment and operations and incident command decisions of that -- so that question before us -- and we can ask other questions. This is just a suggestion question.

Is this approach to risk management appropriate? Is this approach -- is the approach appropriate and flexible enough for small fire departments both career and volunteer and industrial

emergency service organizations? Is more detail needed to assure that ESOs have adequately identified risks and developed adequate plans to minimize or eliminate risks? If so, what additional elements should be added to the plan?

So I want to give everybody a few minutes to look this over, and then we'll ask for comments.

MS. SHORTALL: While the subcommittee is looking things over, I would just like to enter into the record as Exhibit Number 6 Revised Potential Topics for Discussion, a document dated 12/8/15.

MR. INGRAM: Okay, do we have any comments or suggestions or concerns with this paragraph?

MR. WILLETTE: Ken Willette with a question. I notice in paragraph F it refers back to the service -- level of service established in paragraph E, which is directly above. And under that, in paragraph E, under -- let's see, 3ii, there's a definition for special operations service. The emergency service organization shall specify hazardous materials, mitigation and so on. That's a term I'm not really clear how it relates to this discussion. So I don't

know if that was pulled from existing guidance or came out of some other reference material, but what that term "special operation" means.

MR. INGRAM: Okay. Any other --

MR. LEVINSON: So just so that I'm clear, Ken, you're just saying you don't like the term or don't understand the term "special operations service," and you want some other technical rescue or some other -- do you have a suggestion for a term that you think works better than "special operations"?

MR. WILLETTE: This is Ken Willette. I just don't see how it relates. It's not a term I'm familiar with in the responder community to describe that type of activity. And it struck me is it a subset of what an emergency response organization does or a skilled response organization does or is it something else. The term I'm more familiar with is "technical rescue/technical operations," nothing special. But I don't know if that term is comprehensive enough for what you're trying to cover there.

MR. LEVINSON: So if we just change "special services" to "technical services" or "technical

operations"?

MR. WILLETTE: From my perspective, that resonates with me better, yeah. I have a better understanding what that means for fire services.

MR. MORRISON: I think -- Pat Morrison. I think, two, Ken, that will help us later on down the road where we are hopefully in her designing that if you are going to do special technical services or technical operations, that you have to have that skill, you have to have the training for that. And that ties in pretty closely to what we're -- I think what we're going to be talking about then.

MS. TRAHAN: Mr. Chairman, would it be -- just for organizing this subparagraph, would -- I mean I think fire suppression service is pretty self-evident. But then if we were to call it here "technical operations" and then define it with a -- in the definition section what that means.

MR. INGRAM: You want to -- Andy, do you want to take that one?

MR. LEVINSON: Yeah. Yeah, no, I think that's -- and I'm just looking to see if we have a definition

of technical -- no, we don't. So yes, I think that makes sense, Chris, if you just -- in E3ii, just make that technical operations and then move all of these examples into a definition and create a definition for technical operations. Right? That's what you're -- yeah, I think that makes sense from a crafting reg text type perspective.

MS. TRAHAN: So it would be something like -- for technical operations, delineate? I mean is that the -- and then define what technical is?

MR. LEVINSON: Yeah, yes. I think we would have to -- for the technical operations expected to provide or something like that.

MR. HAMILTON: Bill Hamilton. It kind of falls back to on the topics of discussion question number four which talks about this paragraph E, establishment of emergency services. These are essentially just lists of examples of different types of services to be provided. And so I don't think we want to -- we think we want -- I mean if we are using it as -- just as a list of examples, it's better -- or hopefully clearer if we list them all out here as

opposed to trying to give them some sort of short title and then use a definition for some of them. And -- but that does -- like I said, it does fall back to the question before as this is just essentially just a -- you know, a list of various examples and should we expand it, collapse it, fix it -- and obviously it needs fixed, but how do we want to do that.

MR. LEVINSON: Right. So your point, Bill, is that having the list here it would be easier for somebody who's crafting one of these plans so that they don't have to go back to a definition section.

MR. HAMILTON: Correct. These are examples because we're talking about we want them to identify the range of services that they provide and grant to the special ops -- here it just lists several different special, different things, but some of them ask as they go further in for identifying -- I'm going to provide EMS service. Well, go further when you're deciding your level of service in the next piece of this that is it basic life support, advanced life support, transport, non-transport, what have you. So --

MR. INGRAM: Could that be a table added in or

would that --

MR. HAMILTON: It could be whatever you suggest it to be.

MR. INGRAM: Whatever we decide. If it's going to be that -- I mean, again, it's going -- it could be a long list.

MR. HAMILTON: It could, and as I said, this is just some examples that we thought of as regularly thought of as emergency support -- or not emergency support -- emergency services, services provided by emergency service organizations.

Yes, Sarah.

MS. SHORTALL: You certainly can put not only just lists of examples in a table. You can also put requirements in a table as well. You just have to remember you can't put requirements into a definition at all. Those have to remain in the body of a text.

MR. INGRAM: And just for everyone's reference, we're talking about page 8, section E. That's where we're at right now. So I had skipped ahead to F earlier.

MR. FONTENOT: Mr. Chairman, this I guess

brings us to a point of why I was so excited about working on this committee is because when I read E1, it says the ESO shall establish in writing the range of emergency service it expects to perform.

And if I remember the charge correctly from NACOSH was that we were to provide a document that would give as much latitude to the HJ as possible. So in other words, once I do a risk analysis and I choose what services I will provide, and then based on those services, that's the level of training and equipment, I will be held accountable to OSHA for it. Is that pretty much what our charge is at this point?

We have an issue and have had an issue for years with an OSHA document that has caused some problems, some issues, and it's 191020, paragraph Q. And loosely interpreted or interpreted by DOJ, by Justice, it says that all firefighters must be operational level, operational HAZMAT. And it's caused -- been problematic for years. So when I'm trying to tie to two together, it doesn't fit. So I'm hoping at some point we can address this issue.

For instance, if I choose to provide only an

awareness-level service, then that should be my prerogative based on what we're trying to do today. But currently I'm being held to another level by a separate OSHA rule. So I want to put this on the table because I feel it's extremely important that we look at it, and I sent some documents to Matt, some interpretations I had, and he looked at them and I think maybe you're still as confused as I was once we looked at them or maybe he clarified them. So -- but I do want to put this out -- to me, it's very important. It's something I worked on for years that I'd like to see addressed.

MR. CHIBBARO: Matt Chibbaro. We have several interpretations on the book that actually reaffirm that, no, firefighters don't all have to be operationally trained. The way HAZWOPER works, it's just like we've constructed this standard. You choose the level, you'd train, equip and deploy your people at that level, and then if you have something bigger you call somebody else. And I reaffirmed with DEP that those interpretations are still valid. So we're good --

MR. LEVINSON: That's Directorate of Enforcement Programs for people who don't speak OSHA, our field enforcement operations.

MR. CHIBBARO: Kenn, you mentioned DOJ.

MR. FONTENOT: I sent you a letter from Justice.

MR. CHIBBARO: Right, right, right. Now they can interpret their rules, but we've interpreted ours I think fairly clearly.

MR. FONTENOT: Well, the issue has been and been to a couple cycles in NFPA 1001 firefighter pro qual is that we were always mandated that it must be operational level for your basic level firefighter, and we felt that it was a level above the requirement. And if your organization had the DFAR to the firefighter 1, then they should do the additional training to meet whatever level you need. But to be forced to do it when it wasn't necessary is causing a lot of problems in the fire service. I do want to bring this up because it is a big issue, an important issue.

MR. LEVINSON: So let me clarify. So it sounds like it's not OSHA. We don't have that

requirement in our HAZWOPER standard. It sounds like is that -- within NFPA 1001 that every firefighter must be HAZMAT trained for -- is it -- I think it used to be 472.

MR. WILLETTE: It is a -- Ken Willette. It is a requirement of 1001 in the -- to Kenn Fontinot's point, the rationale of the technical committee had been pointing back to the interpretations of the OSHA guidance on implementing 1910.

MR. LEVINSON: Okay. But it sounds like they're not OSHA interpretations. It sounds like there's a mistaken interpretation?

MR. CHIBBARO: No, there are several interpretations that say you don't have to be -- so it's not like there's a misunderstanding --

MR. LEVINSON: Yes.

MR. CHIBBARO: -- of what OSHA requires --

MR. LEVINSON: Apparently so.

MR. CHIBBARO: -- amongst the --

MR. LEVINSON: Apparently so.

MR. CHIBBARO: -- NFPA 1001 -- or committee and some of the fire service?

MR. FONTENOT: There seems to be, yes.

MR. LEVINSON: Okay.

MR. FONTENOT: And I think it would be interesting to get a clear interpretation if that's possible. I know that may be somewhat problematic, but it is really important.

MS. SHORTALL: Mr. Chibbaro, do you think it would be possible to provide a copy of one of the interpretations --

MR. CHIBBARO: Yeah, there are several in there --

MS. SHORTALL: -- for the members?

MR. CHIBBARO: -- consistent. I can provide them all.

MS. SHORTALL: And that we can enter it into the record here.

MR. LEVINSON: Perhaps, you know, during lunch or certainly before this afternoon, right, we can probably print out one of those letters?

MR. CHIBBARO: Yeah, I believe I can put my hands on them pretty quickly.

MR. LEVINSON: Okay. So maybe we can resolve

this issue before today.

MR. FONTENOT: Well, you know what, and it really ties into what we're trying to do overall. It was just one of the big sticking things that I was bringing to the table. I'm really happy that we're kind of all on the same page today at this time. Thank you very much.

MR. INGRAM: Go ahead, Pat.

MR. MORRISON: Can we just -- Pat Morrison. Sarah, can you clarify -- you just stated that we can have a table and in that table we can the list of perhaps operations that we're doing within and we can list out the requirements I guess within that table. But you said in the -- we still need -- I was just a little confused. We cannot put in something in that table; it has to be in the main body of the text.

MS. SHORTALL: You can have a table of examples if you like. It's usually called a figure or table that we put into and refer to in the body of regulatory text. You can also put regulatory text in table format, sort of like if-then format. And we have done that in some other standards. What you cannot do

is place requirements on employers in the definition section. They have to be in other sections of the proposed rule that you will be helping to craft. So if there's anything that includes requirement, keep that out of the definition section. We even have to remind ourselves to do that, too, so --

MR. TROUP: Bill Troup. I had a quick question. When we talked about technical operations under the, what, under the -- I guess 2i for special operations service, I wonder if we can break that into two sections because the NFPA has done a great job in its technical rescue standards in defining what is technical rescue which could be a reference for the standard as well as in HAZMAT. So we have technical rescue and then HAZMAT is two different sections rather than just lumping them all together in special operations service because you'll have -- you'll have an NFPA standard to reference for each of them and that will also help comport with the OMB circular in 119.

And I've seen -- again, the fire service understands the NFPA technical rescue standard. We understand the NFPA and the HAZWOP or HAZMAT standards.

So instead of lumping it all together under technical operations, you do technical rescue and HAZMAT. And then under each you reference the appropriate NFPA and OSHA standards.

MR. LEVINSON: This is probably an important point to jump in on. We should be careful about how deeply we get involved in hazardous material operations issues, because there is an existing OSHA standard that will not change regardless of what this committee does. So that standard still is in effect.

The hazardous materials piece is mentioned because there is one spot in here where we do -- we did provide some suggestions that go above and beyond what's in the current HAZWOPER standard, and that is in particular for the PPE that is used at those events, and we suggested the NFPA requirements for emergency responder hazardous material equipment on the notion that the current HAZWOPER PPE may not be sufficient for emergency responder operations. But that was really the only thing that went above and beyond what is already in HAZWOPER. So this is not rewriting, this is not supplanting HAZWOPER. You could only add

additional requirements that go above and beyond what's already in HAZWOPER.

MR. TROUP: Which would probably strengthen the argument about pulling it out and making them two different areas, you know, like have HAZMAT, see existing OSHA standards and to have a whole separate technical rescue standard referencing the great work of like 1006 and 1670 and all the other NFPA technical rescue standards. Because, you know, the HAZMAT stuff will be so small.

MR. LEVINSON: Right. Well, unless the committee feels that there's a lot more to do on HAZMAT beyond what's in the HAZWOPER standard.

MR. TROUP: So it's just -- you just break the two up.

MR. INGRAM: So it would just be a reference over. Okay.

MR. TROUP: And also help to comport with the A119.

MR. INGRAM: Okay. Any other comments or suggestions here?

Go ahead, Ken.

MR. WILLETTE: Ken Willette with a question on section F, risk management plan. I'm assuming the intent, as we look at this, is the -- it's a risk management plan addressing the risk faced by the individual. Because in this document we've talked about community risk assessment and we -- I think we might have defined that. We talk about risk analysis. We define that, but we don't define risk management plan.

In terms of giving guidance to the organization, you're looking at the risk faced by the individual either responder for skilled support worker, not by the organization and not by the community. And I just offer that because it seems to be a different level of application of doing the analysis and the plan. You're getting more towards the personal risk.

MR. LEVINSON: No, I think -- and Bill may want to jump in on this, but the way that this is suggested is that this is an organizational risk management plan. So you do your community assessment. Then you say here are the services we're going to

provide.

And then once you've done those two pieces, now you come up with your risk management plan that says how are we going to do administration, facilities, training, et cetera; how are we going to build our organization toward that risk assessment and that statement of services that we expect to provide?

And the individual risk management piece doesn't come in until you get into the individual emergency incident operations, and that's something that an incident commander would make in terms of risk management based on the facts that they have on that scene, on that incident and then in concert with their plans and their training that they've developed here.

Is that -- Bill's nodding his head yes, that's a fair description of how we intended this to work. So I agree there's a separate individual risk piece I think that comes later in the actual operations section.

MR. INGRAM: Thank you.

MR. FONTENOT: One of the questions I had -- this is Kenn Fontinot again. When we're talking about

community risk reduction, the first thing that came to my mind is: What's a community? So from an operational standpoint maybe a term we might want to consider using might be jurisdictional because it defines it better as opposed to community. So some districts have a community and an outlying area, some only outlying areas with no community. So exactly what is a community? But if you use the term "jurisdictional" then it becomes this is my jurisdiction, this is what I must analyze and do a risk assessment on. I don't know if that would help her or muddy up the waters.

MR. INGRAM: Matt.

MR. TOBIA: This is Matt Tobia. Just in addition to the list of services provided, one of the things that some fire departments do provide is an explosive ordnance disposal capability or bomb squad capability. Although there are instances where that is cooperatively done between local law enforcement and local ESO, it is sometimes exclusively done by the ESO, and that is an area that I would think should at least be delineated if it's intended to be provided. Thank

you.

MR. LEVINSON: Yeah, and so let me say on that one I think on that we need to look at that as an OSHA staff. There's a provision of the OSH Act, 4B1 that says where other federal agencies have authority and jurisdiction, OSHA cannot. And so that may be something where an ATF or somebody has jurisdiction over how bomb squads and EODs operate. And we would need to explore that a little bit.

MR. INGRAM: Okay. Chris and please give us the page and --

MS. TRAHAN: Chris Trahan. I'm looking at paragraph E that begins on page 8 and continues on page 9. And just as a possible way to organize it, I think the suggestion was made to call out these things in a list to make sense to me. And I don't know if it would make sense to someone who was not a professional, who may be a volunteer when they're looking at trying to figure this out. But E3 says that the ESO needs to establish the range of services. E4 says the ESO needs to establish the level of services in what's E3 now but should be E5 says the ESO may not perform -- may only

perform the range and level.

So would it be better to have E3 and E4 closer together followed by a list of both the range and the level of each range in a format that the employer would then -- the ESO would then say, yes, we are going to do this or, no, we don't do that as a way to help people navigate and make those decisions about what services are provided by their ESO?

MR. INGRAM: This is Rick. I'll comment on that if you don't mind also. I think that does make sense and whenever we have an OSHA standard, which we're talking about writing here, I think it is important to have it kind of in a chronological order. And I look at these as -- you know, training is going to be developed from the standard that we write, and that does make sense. If we look at it in an order from which we can train folks, that's just -- I know that's not something we normally consider, but when we write standards at our business, that's the way we look at it. How will this make sense to the end user in a training module or training modules. Does that help?

MS. TRAHAN: I think it does, and based on my

experience and OSHA rulemaking, a lot of times the regulations don't come out in a way that seems to make sense to the person who has to implement them. But if this subgroup were to recommend to NACOSH this kind of principled way of looking at it, it would be considered, I think, by the agency as guidance eventually. So I think it would be worthwhile to try to suggest things to be as simple as possible.

MR. INGRAM: Any other comments on that?

MR. TREML: That will go back to your -- Chris Treml. That will go back to your rules of interpretation, your letters of interpretation if we spell it out where there's no questions to be asked.

MR. INGRAM: Right. So the better job we do, the fewer letters of interpretation Andy and his team have to deal with. Any other comments, suggestions, concerns on this section?

MR. LEVINSON: So that I -- this is Andy. So that I understand, so what you're asking is that we combine the range and level of services into one provision and then provide a table that explains range and level of services together in one place?

MS. TRAHAN: A table or a list. I mean I think you've accomplished much of that under the current paragraph before, because if you flip back and forth it's firefighting and it's structural firefighting, and this is the level following -- I mean I think most of the work is done.

MR. LEVINSON: Yeah, no, I just want to make sure that --

MS. TRAHAN: That's what I was thinking.

MR. LEVINSON: -- we're trying to make sure that Bill and other folks capture the right sentiment of what you're suggesting so that we can run with it.

MS. TRAHAN: I think so.

MR. INGRAM: It should be a simple matter to put together a table. And then if the group decides that we don't like that later, we're still in the early stages, right? So everything is a draft. That's the good thing. We have some time to deal with these issues. But it would be good to at least be able to take a look at it. And then once we get that started, we might be able to add a few things if we need to is my suggestion. Any other comments on this section? We

still have -- we have 25 till 12:00 right now. So we do have a lunch break coming up. We can take it early or we could press on. As Sherlock Holmes would say, crack on. So --

MR. TOBIA: Could we talk a little bit about the medical if it's okay, sir? Can we --

MR. INGRAM: Yes.

MR. TOBIA: -- continue on with the medical requirements?

MR. INGRAM: Absolutely. Do you want to start that discussion?

MR. TOBIA: Sure, so -- and this I'm -- this is Matt Tobia. I'll just ask a question. Under section G, golf, of the responder preparedness, under the medical requirements, it references quite a bit about NFP 1500 and then goes onto the medical evaluation. And I just want to clarify the relationship of the standard to the -- or the regulation to the NFPA standards. And Andy, you could probably speak to this. I know that we're referencing the standards from NFPA. I would assume it was guidance but not reference -- not adopting them in the

whole. Is that accurate?

MR. LEVINSON: Right. So unless you see language that says in accordance with or must follow and then have a full long citation of NFPA in a particular edition, that's incorporation by reference, the notations that you see here are showing where we pulled the language from so that you understand that it's close to an NFPA requirement.

But, no, we're not saying right here that it has to be an NFPA medical evaluation, and we kind of jumped a little bit off F into G, and there's a question six on all of the medical section to kind of guide some of the discussion and -- or point you to some things you may want to talk about.

But as pointed out, the end of question six, it says the section draws heavily from the concepts in NFPA 1500 and 1582, but it does not specifically incorporate these NFPA standards by reference. Is this approach adequate and appropriate?

MR. TOBIA: Which gets to the heart of the issue. And that's where I would ask for the discussion to take place is do we really feel that that is, in

fact, adequate, or do we want to have a more serious discussion about actually adopting them by reference. The leading cause of death among emergency services responders is cardiac-related events, excluding occupational cancer, which gets to whole other issue. But occupational related dates among emergency services organizations, the leading cause of death is cardiac-related events.

And the single best way to prevent them is two-fold: one, an annual physical, and two, some type of fitness, wellness program. And I'll -- Rick, I'll hearken back to when the CDL licensing came in to be -- there was a perception that that was going to be the end of the over-the-road trucking industry as we knew it in America, and it was. It eliminated a huge risk that was associated with over-the-road trucking, but ultimately made for a safer working force.

MR. INGRAM: And for the public.

MR. TOBIA: And for the public as well who share the road with large vehicles. I think the same hue and cry will go up if we adopt by reference NFPA 1582, it will be perceived as being the end -- spelling

the death knell of the fire service as we know it. I don't know that there's another way -- I'm open to anybody's suggestion, but I don't know that there's another way to affirmatively reduce preventable LODDs from cardiac-related events. If somebody's got a better idea, I'm all open to it, but asking people to ask in their own self-interest has not proven to be particularly useful. So I just wonder if this is the time to adopt by reference the NFPA 1582 standard.

MR. INGRAM: Do we -- just a question. Do we have any stats on that actual -- published at this --

MR. TOBIA: Sure. Absolutely.

MR. INGRAM: Can we make that available.

MR. TOBIA: Absolutely. I'm sure the NFPA can make that available. The National Fallen Firefighters Foundation and the USFA all keep statistics on that. By any conservative measure, approximately 80 to 100 firefighters die in the line of duty annually. Fifty of them will die from cardiac-related events. Of those, 70 percent are volunteers; 30 percent are career. Statistically, their average age is anywhere between 40 and 58. They are not the extremes.

We just had a 30 year-old firefighter die this week from a cardiac-related event. We had another firefighter die this week while performing CPR on a victim. So -- and we know that the overwhelming majority of those responders have not had an annual physical, and we are talking about an NFPA 1582 physical that includes that stress test component as a means of preventing preventable LODDs.

MR. INGRAM: So my request as a co-chair would be that you provide some statistical information to the committee, to the broader committee and that we have that -- and that would be between meetings, I assume. So could you give me an idea of when you could have that to us?

MR. TOBIA: I will be able to get that to you within I would say a week to two weeks at the very most. Actually, I can provide you that within a week. I'll provide you the 2014 records to help you with that, the 2014 statistics. Now understand, Rick, that there are three separate agencies that track line-of-duty deaths. And while those numbers may vary slightly, that they will not diverge significantly.

MR. INGRAM: And could you do an opening paragraph to explain that to us, to the committee. That way we'll have that information at our disposal and that might help us make further decisions later.

Go ahead, Kathy.

MS. ROBINSON: Kathy Robinson. I just had a question because I'm not as well versed in the NFPA standards. But is there, for lack of a better word, criteria? I mean do they have to have cholesterol testing or anything like that, an EKG or they have to be able to lift so much weight or go such a distance?

MR. TOBIA: There are -- actually the NFPA 1582 standard is very specific. It talks about candidates and incumbents. And it addresses both of those situations, and it does lay out the essential functions that an emergency services provider will need to -- could be expected to perform, and then matches the criteria for the physical with what they could be reasonably expected to perform under an emergency services event.

And you can -- we can certainly have a discussion about whether it should apply to those

individuals that are doing technical rescue only or those individuals who are doing EMS only. But certainly within the firefighting aspect of this standard, I would offer that it is 100 percent applicable.

MR. ROBINSON: Would it be possible to get a copy of that standard?

MR. INGRAM: Could you provide --

MR. WILLETTE: Yeah, this is Ken Willette, and I can provide a copy of the standard to the chairs, an then they can distribute it to the committee as they see fit.

MR. INGRAM: Okay. And include Bill and Andy on that. So whether this group -- this committee makes a recommendation that we incorporate that by standard or not, we can always make that a reference. You know, so that's a decision that we'll make later on down the road. Can you -- do you -- yeah, can you make that --

MR. LEVINSON: So there are two issues. One is we could incorporate by reference. Then it becomes part of the regulation. You must do it. You can also write recommendations in, then refer people who are

doing medical evaluations to 1582 to look at what is -- what might be appropriate.

And let me raise a point since nobody has raised it yet. We -- the approach that we took was an annual medical evaluation, some broad qualitative descriptions of what would go into an annual medical evaluation, but a lot of discretion left to the individual medical provider, one of the concerns or positions that I have not heard raised yet is the impact on small and volunteer fire departments.

And an NFPA medical evaluation is not an inexpensive item, and we were having the how poor is poor discussion earlier. And so I want the committee to be very clear that if they think that it is necessary for every fire department of every size, career or volunteer to have an NFPA medical evaluation every year, that they should be clear that that's what they're recommending to NACOSH and that they suggest NACOSH recommend to the agency because I suspect that that will be a costly and controversial point.

MR. FONTENOT: This is Kenn. As part of my duties at the fire council -- National Volunteer Fire

Council, I chaired a health, safety and training committee since its inception. And we've done a lot of research and a lot of soul searching. And I've looked at the statistics and, in fact, I asked my cohort, Dave Finger, and staff to generate some data for me earlier this year to look at some of the statistics, and there's a lot of them.

And Chief Matt is absolutely correct. The 50 percent, 55, 60 percent of line-of-duties are cardiac, whether it be cerebral or coronary. And there's also the real world. When we looked at the numbers Dave put together from the fire academy, a lot of the volunteers, they've over 60 years old. You're not going to see that in the career departments because they retire out before. Was it directly job related to being a firefighter or just our turn because we're that old? These are answers in places all over.

Are there some preventables we might catch? Certainly. The younger ones that have congenital diseases, the folks that have developed coronary issues throughout their career, Andy is absolutely right. And after our last meeting I sent a note to the council

saying that this is going to be an issue.

We have supported the issue, but we haven't come out and said we need to do this because it is so expensive. Small departments, medium-sized career departments, it puts a burden -- it will put a financial burden. Will it be the end of it? That's room for discussion. So I'm sort of holding my comments. When we have this discussion, perhaps we can put a block aside next meeting when we have more data to look at and see what will happen. It will become a big issue no matter where it is -- it lands.

MR. INGRAM: I think Matt has more information.

MR. TOBIA: This is Matt. And he's absolutely 100 percent correct. But the IFC is also working right now with numerous partners, many of whom are in this room, to ensure the availability of a physical for firefighters at no cost to the firefighter, which includes -- and by the time we get this standard written, we may have already solved this problem of cost to include using public health officers in rural areas in the United States where there is no clinician,

no provider as well as providing guidance to the family practice physician on how to deliver an NFPA 1582 physical.

So we're extremely sensitive to that issue. I'm extraordinarily sensitive to the idea of an unfunded mandate and what the impact of that would be. I also know that this is the single best way to reduce preventable LODDs and this is by far to a factor of 10 the leading cause of death among emergency services responder. And if we aren't focused on that, I don't know that we're necessarily focused on the things that we should be necessarily focused on. I know it's a hard discussion. I'm not saying that it won't have an impact, but I'm also -- we've got to have the discussion.

MR. WARREN: I'm just -- this is Bill Warren. I'm just not sure that incorporating by reference is the final answer to that specifically to the -- you know, when you look at the volunteer fire departments that represent 60, 70 percent, 80 percent depending on the state, and then the potential fatality rates of what that would mean and what is the cost benefit for

that. I mean I'm really concerned about that part by getting that deep into the reference and saying this is how you will do it.

MR. INGRAM: Kathy.

PARTICIPANT: Yeah, and --

MR. INGRAM: No, Kathy was next.

PARTICIPANT: Oh, I'm sorry.

MR. INGRAM: I'm sorry.

MR. ROBINSON: Kathy Robinson. With all due respect to the NFPA standards and the fire service, because I actually agree with a lot of the stuff that you said this morning about that, it's -- the majority of EMS agencies are non-fire-based services, and the leading cause of death in that particular audience is ambulance crashes and people falling asleep at the wheel due to fatigue. So I think the cardiac component is really one element of that, but there's people that have enormous health costs related to hepatitis, influenza and things obviously not quite as serious as a cardiac arrest or a cardiac event.

And your argument actually does pertain a lot to the EMS population, but I just think we need to be

very diligent in considering all aspects and what impact that has, and I'm actually very pleased to hear you say that you're already looking at ways to fund that because I think we're all for worker health, but we also need to be mindful that we aren't opening a Pandora's box either.

MR. INGRAM: Pat was next.

MR. MORRISON: Yeah, we have the same sort of argument on the career side, even the volunteer side. We have a lot of small career departments that have 25, 15 firefighters in that. And we put together the wellness-fitness initiative between the IFC and the IFF and the number one stopping point is cost justification. That's -- so we'll have -- I'll send out the cost justification that we have as far as what the return is going to be on actually doing this in not only the career side but in the volunteer side.

And I'm -- the different ways you do it -- the concept was that everybody -- I definitely agree with Matt. It's not just about cardiac; it's about a lot of other screening that takes place during that event from the -- health side to the cancer prevention to the

diabetes to the -- I mean it's a whole range of individuals on here that we can take a look at.

But we've had to deal with that, and there are ways that the private insurance -- and it's going to take some more conversation than this right here, but it is that -- I think it's -- the single most important thing that we can really discuss when it comes to the LODDs and the fire service both across the range.

My only question is to the staff would be that this is -- 1582 is not a static document. It's a -- it changes cycle to cycle, and we put in -- right now there's a big, huge conversation on PSA testing and prostate and what other cancer rates on that for the fire service and when do we do testing, when we don't do testing. The cardiac stress test was one area that really has what we call false negatives. Somebody can pass that and all of the sudden come -- still have a heart attack because we missed a couple maybe other areas that we should have tested in.

But how do we adopt -- how does an OSHA document continue to be current and up to date when we put a reference in like under PA, we make that changes?

How does that -- I just don't know how that operates.

MR. LEVINSON: Right. So when we incorporate something by reference, we need to put in a specific edition of the standard. So if it's the 2015 edition, that's what goes in the regulation. Now we have a de minimis policy which means that our enforcement folks allow the current edition of an NC or an NFPA standard to be used in lieu of as long as it's the more current version.

And then we also periodically go back and update our consensus standards. So for example, in five years, when the 2020 edition comes out, we might update in not 2020, but 2022 or 2023. We would go back and we try and keep updating. That's a harder process. You know, it's not a hard process. It's a relatively easy process that is low on the priority list, you know, because we're always working on other regulations.

But there's always that provision for de minimis where you can use the current standard. But let me also just -- because I want to be explicitly clear on all of this.

And I'm not trying to dissuade the committee from going forward from adopting the NFPA standards, but the way that we would look at this issue, for example, is if the committee adopted this and incorporated this by reference, if you had a volunteer fire department that was covered by your state plan and you had 70 people on the roles in order to get four people to show up at a particular incident, we would expect all 70 of those people to have been medically cleared.

And what's the impact? You know, we would, as we were doing this, take the cost for an NFPA medical for all 70 people in that volunteer department, not for the four people who showed up for a particular incident. And I know that it's customary in a volunteer department to have people on the roles who may only show up for one or two incidents a year because you don't know who's necessarily showing up at any given incident.

And so that's how we would look at that issue and we would want to make sure that the committee was certain that that you wanted to recommend having fully

considered the impact of that recommendation.

MR. INGRAM: I think Sarah has a comment.

MS. SHORTALL: Mine are mostly procedural, but since it's still NFPA, let me go back to Mr. Willette.

Mr. Willette, you said you would make available NFPA standards to members of the committee.

MR. WILLETTE: That's correct.

MS. SHORTALL: I take it these are copyrighted materials.

MR. WILLETTE: They are.

MS. SHORTALL: If we receive copyrighted material, we do not put that on our webpage unless an organization who holds the copyright would want a broader release. If you want us to be able to put it on regs.gov, we'd appreciate when you supply it if you'll indicate whether that should be made available beyond. But we have to put it into the record so people would be allowed to come to our OSHA docket office, examine, even make a copy of it. That's one of the -- even with copyrighted materials.

MR. WILLETTE: The -- what I envisioned providing was a digital copy that was watermarked

saying it was for use by this committee only and then providing it to the OSHA team and the chairs. And then if it needed to be distributed to the committee members, that could be done through email. Would that meet your needs?

MS. SHORTALL: Certainly meet our needs, but if you provide a watermarked copy it still -- if it doesn't indicate that it contains the copyright, we would --

MR. WILLETTE: Right.

MS. SHORTALL: -- put it up on our webpage. So if you want the copyright to be preserved, you should let us know or make sure that whatever you provide us does, in fact, include that copyright.

Then question number two that Mr. --

MR. LEVINSON: So Sarah, before we get to that, so one of the things we can do, Ken, and we've done this, is we can put the cover page, the title page from the standard and perhaps the table of contents in the public docket so that people can see what is covered in the docket without seeing the actual text. And then people can come to the docket office to view

it if they need to.

MR. WILLETTE: Just for clarification, that standard is available to the public for free in a view-only format. If we provided that link, can you -- posted that in the public document, would that fulfill your needs?

MS. SHORTALL: Well, certainly it would allow -- if you want to do view-only. I do not believe our regs.gov has the capacity to have a view-only document that people could not download. So that may present a different problem. But that -- you know, you certainly can contact me -- my information is on the list -- if there are additional things to guard your copyright, and we can make sure to put that.

MR. WILLETTE: Thank you.

MS. SHORTALL: As to Mr. Warren, in your comment about the difficulty of some organizations following something like NFPA, in our rulemaking capacity, we are required under section 6G of the act that any time there is a national consensus standard in which our standard would substantially differ from it, we must identify the way in which it differs.

It must explain how whatever we're contemplating doing is at least as protective as what's in the national consensus standard. I'm not saying which way to go, but if the subcommittee does want to do something that's different, they would have to provide the rationale for why this is as protective as what's in the other policy.

And then the third thing would be, as Andy was saying about the de minimis policy that we have, if you follow a more recent standard, we're required to put a specific dated standard in our standards because the Secretary of Labor -- or Congress has delegated to the Secretary who in turn delegated to OSHA the requirement to do standards. We did not -- she did not delegate nor did the Congress delegate it to the NFPA. And so, we can only adopt something that's time-certain.

We can't just give over to the NFPA, you can do whatever standard and we'll put the other one -- because it may not be as protective as -- so, we will follow -- this policy if that newer standard is at least as effective as, and OSHA always does examine the two standards side by side to make sure that they're

always done.

So, if we do allow that de minimis, it's because the agency has judged this at least as protective as.

MR. INGRAM: I think Chris has a comment, and then, after this comment, take note of what Chris has to say, because we're going to take a break for lunch.

So, go ahead, Chris.

MR. TREML: Thank you. Chris Treml.

I do agree with what Mr. Tobia said about the emergency responders needing to be physically fit, you know, adrenaline pumping, the whole nine yards, and being on the scene of an emergency incident.

My thing is where -- and number 2ii, where it says "each," "Ensure each responder or skilled support worker is qualified as meeting the physical performance requirements established by the ESO prior to entering into a training program or becoming a responder.

I mean, in today's world, I don't know of too many people in the -- you know, in the tow truck industry or in the construction trades that are the most physically fit individuals in the world or who

would pass the same physical requirements as someone that's doing day-to-day operations in a fire department.

So, I don't know if there should be a separate -- somewhere that should be -- somehow that could be separated. That's my only question. Because they're not going to be -- they're not going to be doing the same -- the same job task when they reach there.

A tow truck driver is not going to be doing the same thing as, say, a firefighter would be doing.

MR. INGRAM: Okay. Thank you very much. Okay.

MS. TRAHAN: Hi. Chris Trahan.

While I agree with you, I wanted to raise a different issue.

In the construction, we have something that is a rule that pertains to hardhats, and the ANSI standard that was cited in that standard was from 1968, and it wasn't until 2012 that OSHA updated the requirements in that OSHA standard to more current ANSI standards.

So, I think there is a risk -- just from my experience, there is a risk of incorporating by

reference a specific date of a consensus standard.

I just wanted to raise that for information.

MR. INGRAM: Okay. Thank you.

MR. LEVINSON: To get to the point you just made, Chris, if you look at the skilled support document that they provided, there is a separate section for medical requirements for skilled support personnel.

So, I think the way that the committee was headed, everything for the skilled support personnel, skilled support workers, would be in that section, and that this section would only apply, ultimately, to emergency service organizations.

MR. TREML: All right. Well, I'm just -- I'm reading it there and it said "all skilled support workers." That's why I brought it up.

MR. INGRAM: All right. I believe -- so, we're going to take a lunch break from 12:00 to 1:00. We'll come back at 1:00, so it will be five minutes shorter, but Sarah has a couple of comments.

MS. SHORTALL: I'll do this real fast, then:

I'd like to enter in the record as Exhibit No. 7 the revised table of contents of the Draft Emergency Responder Preparedness Program Standard dated 12/7/15.

MR. INGRAM: All right. So, we'll see you back here at 1:00 o'clock.

(Whereupon, at 12:02 p.m., a luncheon recess was taken.)

A F T E R N O O N S E S S I O N

MR. INGRAM: Okay, folks, we'll go ahead and reconvene the meeting.

Good conversation before lunch.

What we've decided to do -- we're going to continue the discussion about medical evaluation requirements and physical performance requirements briefly, and just finish up that conversation, and then Lamont is going to take over, and we'll go back to risk management plan. Okay?

So, are there any other comments, questions or suggestions, or concerns, about what we were talking about before lunch? Anything to finish that conversation up.

MR. TOBIA: This is Matt Tobia.

Andy, I have a question for you. Is there a way to -- without adopting the standard by reference, is there a way to meet the intent of the OSHA regulation by meeting the standard?

For example, are there circumstances under which OSHA says, if you meet this, you have met the intent of the medical -- of the standard.

MR. LEVINSON: Right. Yes, we could provide a safe harbor where we say you must do this or, in the alternative, if you do this, that will be deemed to be in compliance, and we had talked about that at an earlier meeting as, you know, something, I think, you know, that we were thinking about for training, and that's something that we could think about, you know, for this, as well.

MR. TOBIA: Okay. Good. I just want to get that out on the record again. You know, instead of getting into a -- adopting it by -- you know, adopting by -- by reference or not adopting it by reference, there's still a method by which organizations could meet the OSHA requirement for medical evaluations, and they may already be doing it.

There are departments out there that are already doing NFPA 1582 physicals and may be able to meet it that way. Is that correct?

MR. LEVINSON: Yeah. Absolutely.

MR. TOBIA: All right. Thank you.

Mr. FONTENOT: Andy, I have a question. If I remember it right, either at the indoctrination at the

last meeting, it was said that, if there were certain parts of this document that would seem to be very expensive to the populace or the audience that the document was for, that we could do a cost analysis, an impact analysis? Is that big and cumbersome?

MR. LEVINSON: Yes, that is tremendously big and cumbersome. We have to do that for the entire document --

MR. FONTENOT: Okay.

MR. LEVINSON: -- as part of the proposal. So, that's not something that we could do, you know, now, as part of the committee process, but it -- but we will have to do that, and we'll look at it -- you know, typically with different alternatives. So, yeah.

MR. FONTENOT: Thank you.

MR. WARREN: So, Andy -- Bill Warren. As you do look at the economic impacts of -- of the statement and the things that you're going to do there, would you be -- primarily on those states that it would have major impact, like the state plan states? Because you know, one of the concern I think the state plans would have is -- is utilize the Federal state -- there's not

going to be a lot of economic impact to those where they would be under compliance under the state plan states.

So, I would just like to encourage OSHA that, if you do the impact statements, that it's exclusively on those states that have that impact.

MR. LEVINSON: So, let me parse this out a little bit more.

So, when we do our economic analysis to look at the costs and benefits, we would look at the economic costs and benefits of everybody who we believe would be covered by the standard.

So, we would go through and say everybody, regardless of whether you're a Federal or state plan jurisdiction, who is a private sector industrial-type emergency response organization is covered.

So, we would scoop all of those people into both the costs and the benefit analysis, and then, where people differ by state -- so, for example, career in a state plan state versus career firefighters that are in a Federal state -- we would look at how many firefighters are in that state that has coverage, and

then what we would do is we would then even go below that and say, okay, when you're looking at volunteers, these are the states that are state plan states that include volunteers, and how many of those volunteers, because there's different thresholds within each of the individual state plan states about which volunteers and what level of compensation is enough to be called a worker.

So, yeah, it's a very extensive analysis and would cover not just everything that you said but go beyond that.

MR. WARREN: Thank you.

Mr. MORRISON: Andy, Pat Morrison. How do you cost out -- let's just say we're going to do an annual medical. Do you have to actually cost out that annual medical --

MR. LEVINSON: Oh, yeah.

MR. MORRISON: -- all the -- all the different --

MR. LEVINSON: Yes. So, we would say, for example, the typical costs of doing an NFPA 1582 medical is -- and I'm going to throw out a random

number -- $1,500 a year. I don't know how accurate that is, but I think that that's probably not that far off.

So, we would say here's the medical. Here are all the tests that are involved, you know, in doing that. So, it will be pieces of that.

We would then typically also say, okay, doing a medical takes, you know, two hours' worth of time between all of the -- so, we would say that there is a dollar cost, you know, for that. You know, there might be travel costs factored in.

But yeah, we would go through very explicitly and say, you know, in particular, if you have 70 volunteers, even if you only have four or five people show up at a particular incident, we're going to assume that you have done a medical on all 70 of those people, you know, who are eligible to be responders.

So, that's one of the reasons I'm kind of putting a finer point on this, because this is going to be one of the bigger ticket items, and it's not just an initial cost; it's an annual cost.

MR. MORRISON: If it's done annually.

MR. RODGERS: If it's done annually.

MR. TOBIA: This is Matt Tobia. Do you also factor in the cost savings associated with doing the physicals? For example, do you assess the economic impact of having a workforce that is getting an annual physical and, therefore, not experiencing a cardiac event that may cost them $250,000 for the jurisdiction, a single cardiac event?

MR. LEVINSON: Yes. So, that's the benefits half of the cost-benefit piece. So, we would say, okay, if there are 100 fatalities a year and 50 or 60 of them are cardiac-related and we think we can prevent 20 or 30 of those, we would take the benefits of those 20 or 30 lives saved annually, typically a cost of around -- I think it's $8 1/2 million per life saved, and then we might also say, okay, we think that we're going to avert X many cancer deaths or -- you know, and so, we would go through all of the different benefits that, you know, we might catch in the medical -- diabetes before it gets to a, you know, more adverse state, and so, we would go through all of the information, probably a lot from the IFC/IFF wellness

fitness initiative and say here are all the benefits that accrue from that.

What I will also tell you from an OSHA perspective is that nobody believes our benefits, and everybody believes that all the costs are underestimated.

MR. TOBIA: And I would just be careful, Andy -- I know that -- you know, I know we're just throwing numbers, but of course, you're automatically an expert of your position.

I have seen numbers where an NFPA physical is $500, you know, and I just -- I just want to be careful, because someone is going to leave here and say NFPA physicals cost $1,500, and therefore, that is cost prohibitive to the world. I don't want to assume that.

I mean -- and then there are some jurisdictions -- are, quite honestly, getting it for free, because they've partnered with local -- local healthcare providers to do that.

MR. LEVINSON: And our economists would actually do a much more sophisticated model.

So, they would say some percentage of the

large fire departments run their own in-house medical staff, and it costs them X, and other people pay, you know, fee for service, you know, and others get it for free, and that they would make estimates of an economic model of what the world looks like, with probably a couple of different price points to represent how different people access those services.

MR. INGRAM: Chris.

MS. TRAHAN: This is Chris Trahan.

So, as someone who has participated in OSHA rulemaking a lot over the years, as someone who participates in the public process, which happens after a proposal comes out, they put all this on the table, and they say this medical test is priced out at $146. Please, you know, let us know what you think of these estimates and what these medical tests actually cost in your experience, and that's part of the process of rulemaking, is that the public will be able to say, well, this one really costs 800, this one really costs 2 dollars, the time involved, and you get to give specific feedback on all of the basis for the costs that OSHA calculates during the rulemaking, but not

during this meeting.

MR. LEVINSON: Right.

MR. INGRAM: Chris Treml.

MR. TREML: Chris Treml. Just one point that -- as far as the medical -- the medical testing goes, many skilled support workers are already going to be coming in with a CDL license, which they have to pay for testing for, which is -- I know it doesn't -- probably doesn't meeting the same requirements as the -- the NFPA, but it's still -- still a cost to be considered at the end of the day.

MR. TOBIA: And likely better than what most firefighters are getting.

MR. TREML: Oh, really?

MS. TRAHAN: Yeah.

MR. LEVINSON: We would not consider the cost of a commercial drivers license test, because it would not be required by our regulation or by our standard.

Now, that could, for example -- if you said a CDL medical is sufficient for skilled support worker and that that could be use in lieu of an additional medical, if the committee felt that that was

appropriate, you know, that's a way that we could diminish costs, because we could say, you know, X percent of the skilled support workers already have a medical evaluation through the CDL, the employer would not have to do anything else for those people, and we only have to take the cost for, you know, the percent that's left.

MR. TOBIA: I have a super granular question in one of the sections.

Under section G, responder preparedness, number 2ii, it just talks about -- and this is a granular question, but it says each -- each -- ensure that each responder or skilled support worker is qualified of meeting the physical performance requirements established by the ESO prior to entering into a training program or becoming a responder.

And I guess my question would be, under this, as it's currently written, could an individual -- as long as the -- as long as the requirement was met prior to them becoming a responder, could they not enter into a training program without having met the verification of physical capability?

And I point very specifically to individuals who have entered a training program and died during the training, because they did not get a pre-training verification of the ability to meet the physical requirements.

So, I just -- I don't know if there's a wording change that might need to be made or considered by OSHA. My thought would be that there would be a period after -- after the word "program," so "prior to entering into a training program," period, and then a separate requirement for individuals becoming responders, because you will, of course, see individuals who are already trained leave one jurisdiction, go to another jurisdiction, they don't need to enter a training program, but they're about to become a responder in a new community.

If I move from Harrisburg, Pennsylvania, to, you know, Loudon County, Virginia, and I want to be a volunteer firefighter in Loudon, I've already completed my training; I don't need to enter a training program.

So, I just -- I know that words have meaning. I would just ask OSHA to look into perhaps parsing

that out to ensure both are met.

Thank you.

Mr. TROUP: Bill Troup. I just have a question, basically.

Are medical requirements and physical performance requirements different? Because I looked at medical as actually having the physical portion and the physical performance requirements are actually going through like a -- almost like a CPAT type thing or -- you know, like a physical fitness test.

I think they're two different things, aren't they? I mean, is that the way -- the intent of the standard?

MR. INGRAM: So, that's a good question. Can anybody respond to that?

Ken.

MR. WILLITTE: Ken Willitte.

As I see the citations back to NFPA standards, it's clear that 1582 and 1584 apply to medical, and the reference to 1500, I think, to Bill's point, does apply to the performance, the physical performance that the candidate has to demonstrate and is not a medical

evaluation.

MR. MORRISON: Pat Morrison.

It's not a medical evaluation, but when they're going through it -- and this is where it really gets tricky for us even on ADA -- you can't -- you've got to be very careful about having certain requirements, because there were certain requirements to have an annual medical -- or having a medical prior to that, and that was a -- that was a condition of job employment, too.

We ran into that with the candidate physical ability test, the CPAT test, but the test itself -- anybody running those tests would tell you that -- anybody in any jurisdiction -- you really want to have some sort of medical clearance before doing that.

That test is like a stress test. I mean, it's not -- it's not unlike that. So, we do -- we do have that requirement.

I'm not sure if we -- I mean, it's really quite -- I mean, to me, it's not -- this is not that complicated in the sense of -- at NFPA, we've been talking about annual medicals for a long time. That's

just been a requirement. That's in there. It's in there now. It's in there for both career and volunteers.

There's not -- I don't think there's a real discussion on that. You know, there's always been that point.

NIOSH, after every line-of-duty death investigation, I can tell you right now, if you go back and read their report, they will tell you, an annual medical evaluation should have been -- should have been performed, and it's, you know, from NIOSH to NFPA.

It really comes down to the cost item of something, and then it comes down to how you get that.

The concept is -- and I'm glad -- what Andy had presented was that -- you say that you get an annual medical. We have to kind of define that and how we get to that -- to that point, because that's the -- the thing we're talking about here is just dollars. It's just money. I don't think there's anybody says that you don't need one. You do need one.

So, you know, how do you fund that? There are a lot of departments, big departments -- I'm not

talking volunteer departments, I'm talking career departments -- that have chosen not to fund it. I mean, you know, they just chose, in their budget, that they're going to spend their money in other areas and not on an annual medical for their employees, and there are some small departments that have figured out, 25-member departments that have figured out how to do an annual medical through their own health insurance policies to get pretty close to what we're talking about there.

So, at the end of the day, it really is that we are going to have to put all these things on the table, and then -- you know, and I'm glad we're doing the cost -- you know, the cost -- what it's going to cost and the benefit piece, but that's what we're -- I think that's what we're discussing here, because if anybody -- if the discussion was should we or not, I'd like to have that discussion, because I don't think that's really on the table here.

It's, you know, really, how -- you know, it's going to be, what is the impact on some of these departments? Is it going to be, you know -- you know,

financially, can they not afford it?

I think, financially, you know -- you know, they can, but it's different means to get there.

So, we'll have that discussion.

MR. INGRAM: So, I have a question for our experts here, and our economists that happens to be in the audience.

So, is there a way to know what percentage of the volunteer fire departments -- and I assume we're talking about volunteer fire departments here, maybe even professional ones, too.

MR. MORRISON: Oh, absolutely, yeah.

MR. INGRAM: So, what percentage of firefighters, be it volunteer firefighters or professional firefighters, have an annual evaluation?

MR. TOBIA: Rick, I'm going to give you the very difficult -- this is Matt Tobia. I'm going to tell you the -- I'm going to tell you very difficult things.

Number one, at this moment, nobody in the United States can tell us exactly how many fire departments there are in the U.S. to a statistical

certainty.

There is some very close estimates, but there's no way to factually know exactly how many fire departments that are in the United States.

There are, by most general numbers, about 1.3 million firefighters in the United States, career and volunteer.

The issue that you point to is the most -- is a confounding challenge.

Can we give you some estimates? Absolutely. Is there any way to give you a really hard number? No. But the number is small. I would offer that. The number of firefighters who are getting an annual physical, an annual medical evaluation of some kind, of the 1.3 million, is very small, and I'll defer to Ken and Pat.

MR. BYRD: I just wanted to clarify one thing. There was a reference made to CDL medical examination. CDL-qualified drivers do have to get a medical examination, but actually, it's commercial drivers, all of whom do not have the commercial drivers license.

So, the trigger for the medical examination is

operating a vehicle in commerce at 10,001 pounds or greater. That's the general -- the general definition.

The second point I'd like to raise, in terms of doing the medical examination for, say, firefighters under the NFPA standards, is what type of medical or healthcare provider is qualified to do that type of examination, and if there are some, you know, some criteria that that person or those people have to meet, that's something that we need to factor in.

MR. MORRISON: Pat Morrison. There are certain requirements, but the general requirement, what the IFC is working on now and what we've been -- we've had in the past is to take the NFPA medical and put it down in a checklist so that an individual firefighter that has to go for their annual medical can take that actual form to their physician, because the requirements for this individual is going to be much different in that same age requirement, somebody else coming in for their annual medical, not in regards to firefighting.

That general practitioner could probably do 95 percent of the medical screening, I would imagine. If

you did a cardiac stress test, that is the specialty test that we would like all firefighters to have at least a baseline. That's a baseline. Sometimes that's a -- and that -- that baseline -- and it can be age-dependent.

So, in some of the occupations or some of the centers that we have, that firefighters or fire departments have their own medical -- a certified -- we call them an occupational --

MR. LEVINSON: Board-certified occupational medicine physician.

MR. MORRISON: Right. And that is another certification that people have, but that's not necessarily the requirement that has to be met from -- from doing the medicals that we're talking about.

MR. BYRD: Okay. Because that's the point that I was getting at. Is it restricted to physicians or could an occupational nurse do the physical?

MR. MORRISON: We have plenty of -- we have plenty of nurse-practitioners and PA's. In some of your bigger departments, they use those, they employ those, so -- those individuals to do it, and that --

thank you for bringing that up. That's a perfect example of who can do these medicals.

They are usually under the guidelines of a physician, you know, as far as if they have to do any -- any medication or anything else. There are some guidelines there.

MR. WILLITTE: Ken Willitte.

I'll get the language out of 1582 that talks about the requirements of the person doing the medical screening so that at least you'll have for reference, and to the question of, do we know how much of the fire service has had physicals, NFPA does every five years what's called a fire service needs assessment. The last one is five years old, was done in 2011, and we're just conducting our fourth needs assessment now.

One of the questions that was asked, do you have an annual physical that's compliant with NFPA 1582, and I'll provide you with the results of previous survey, but one thing I can tell you -- and I think it speaks to who's going to be impacted the most by the actions of this regulation -- the largest unmet need across the board was in communities serving populations

of less than 5,000 people.

So, no matter what the topic was in the survey, including not having medical evaluations, it was those departments protecting communities of less than 5,000 population.

That goes right to the volunteer service and those departments that are doing barbecues to keep lights on and gas in the vehicles.

So, that's just a frame of reference for our conversation.

MR. INGRAM: Anybody else?

MR. LEVINSON: So, let me ask, did we change anything from the text that we offered? Moving forward, you know, is there -- is there a suggestion? Is everybody fine with this the way that it is?

We had talked a little bit -- I think, you know, Matt's point about, could we put in a, you know, safe harbor that says, if you're doing a 1582 medical, that that's deemed to be in compliance with the requirements of this section -- is that the only change?

MS. ROBINSON: I'm finding it hard to be in

agreement or disagreement, because I'm not familiar enough with the standard, and so, I think once we have a chance to look at that and see what components or elements of that would be satisfactory, I think I personally would feel better.

MR. FONTENOT: Andy, I was under the impression that we're going to get more data for your next meeting from Matt. So, I'm very uncomfortable signing off on it as it is now.

Like Pat, I don't think it's a discussion of whether or not you do it; it's how it gets done and the way it gets done.

MR. LEVINSON: So, let me suggest for perhaps the next meeting -- and I think you can think about this and we can revisit it at the end of this meeting -- would it be helpful to bring in a medical professional or two, perhaps somebody who is on the 1582 committee and/or, you know, a fire department doc who -- and/or perhaps somebody who's done emergency -- who has done medical for skilled support workers and have a discussion so that you can have the benefit of their wisdom during the discussion, and if so, if you

can either think about specific people or types of people, and we can find somebody for the next meeting.

MR. WARREN: My only caveat would be, Andy, is that, in listening to what Ken had to say, you know, I think the bigger concern is going to come from those departments that are 5,000 and below.

Do we have any representatives that could represent them, whether it be a -- if there's going to be a physician within -- that services some of those kinds of departments?

I don't think the bigger departments are going to have that much trouble -- I think it is the 5,000 and below elements -- that's where I think I would be most concerned with.

So, is there a way to do that, bringing an expert in who kind of services that -- that kind of a demographic?

MR. LEVINSON: I think that can certainly be one person, you know, among the panel, and what I would say is, if the NVFC or the IFC or the IFF has, you know, people who service those, you know, smaller communities and you have a recommendation for somebody

who can speak knowledgeably about that, you know, let us know.

MR. INGRAM: So, I think the other thing that we talked about was getting some additional statistical data. So, that would be helpful, and any statistical data that we could get, I think, would be very helpful as far as, you know, how many -- so, the survey that you talked about from NFPA, the actual fatality data -- that would be good, and then -- so, I would suggest, having said all that, that we table this discussion until the next meeting and then take it up again.

Go ahead, Chris.

MS. TRAHAN: One question. Is that fatality data available by community size? Is it broken out in that manner, like rates of firefighter fatalities based on the size of the community or the size of the department?

MR. TROUP: Bill Troup. USFA just released its 2014 report, I think, a couple days ago, and I'm going to send that you all, and I was showing Matt some of the figures that came out of our most recent fatality report. We break it by career and volunteer,

and we'll get that report to you all. That's public domain, no copyright or anything like that. That's available on our website.

MR. INGRAM: The other -- the other thing that we discussed -- thank you, Chris and Bill. The other thing that we discussed was EMS folks. Kathy brought that point up, that we're not just talking about firefighters here. We're talking about other support services.

So, is there anybody from any of those groups that we might want to pull in to speak to the group as a guest speaker? Is that appropriate?

MS. ROBINSON: I can help with that.

MR. INGRAM: You can help with that? So, let's -- so, you've got an action item to do that, and then, Ken and Matt both have action items to bring in some statistical data.

Anybody else got any suggestions for this ongoing discussion?

Go ahead, Ken.

MR. WILLITTE: Ken Willitte. Just to follow up on Andy's suggestion, if you want we can reach out

to our technical committee, which has several docs on it, and see if they would be available and coordinate with you and perhaps have a member of the committee or our staff liaison do a brief overview of the document, if that would be helpful.

MR. INGRAM: So, I think we all agree that a best practice would be to make sure that every person that responds to an incident has some type of medical evaluation.

If my son was -- if my son or daughter were responding, I'd want them to have a medical evaluation, so I should want that for every person out there doing the same thing, to help them get home safely at the end of the day.

The question is, will it happen? And then I know we have state plan states. We have issues with that, as well, where that might or might not be able to happen.

Go ahead, Pat.

MR. MORRISON: Just some clearing-up.

When we say firefighters, I know we represent a large proportion of EMS providers, some that are

single-role, some that are dual-role in that they run on an EMS vehicle and then they can come over and to the fire side. So, a lot of that is cross.

Kathy does represent a lot of -- that stand alone -- the EMS standalone, and there are a lot of people out there, I think, we could get with -- with the EMS issue on there, too.

I think with -- Tom is not going to be around here too much longer, but -- I know he's retiring, but he would be an excellent one that I would suggest, from NIOSH, at the appropriate time, Mr. Chair, that we would -- we would probably want to bring in to clarify some of the importance of this.

MR. INGRAM: It's obviously a very important topic, or we wouldn't have taken so much time with it, so good discussion, and try to -- of course we'll get the minutes of this meeting, but try to remember the things that we've talked about for the next time and we'll -- we'll carry on, and once we get the minutes, you know, you'll be tasked to read through those and make additional comments.

Does anybody else have any comments on this,

or questions?

MR. TROUP: Another quick question on Chapter 4, the health and fitness component. There's a lot of tasking, the three-year fitness assessment and stuff like that. Would such an outside expertise -- may be helpful with something like that.

How would a department, whether it be large or small -- what's the experience like in a large department, like -- you know, like a large city department with, you know, a three-year physical assessment? Do they -- is that commonly done or --

MR. MORRISON: Pat Morrison here. There's some changes on that. I mean, it varies a lot. Most of -- we have a lot of large departments, metropolitan departments, that are large in numbers, over 1,000-plus firefighters, that don't do annual medicals.

Most of it is a annual -- we like a baseline. A baseline is just -- you know, you get some of the bigger test items out of the way and then you do that -- because you're looking for effective change, and the baseline was so important for us for the fire service, especially -- and I'll just give you an example real

quick, 9/11.

If we didn't have the pulmonary function baselines on those firefighters, we didn't know what the significant drop was in their -- in the lung capacity, but we did know that it was a percentage, and that really did help with everything going on today.

But baselines for a department size of New York City, all the way down to, you know, a small, small department is incredibly important for exposure protection, for, you know, what did they come in with.

A lot of municipalities want to do a medical -- a lot of states are driving medicals, because we have cancer presumption, we have heart and lung presumption, and they would like to see the firefighters coming in -- they're not bringing something in from their -- whatever they were doing, whatever their employment was.

So, there is a screening. There's a lot of push to have an annual medical -- medical requirement just in the pension process to make sure that firefighters coming into the job are not going to claim an item that did not happen on the job; it happened

someplace else.

MR. TROUP: Yeah, I was just curious.

Also, with regards to the thing about the fitness assessment, how commonly is that done throughout the fire service, that departments have to do a three-year fitness assessment.

MR. TOBIA: For departments that are participating in the wellness fitness initiative, you know, that fitness assessment is a big component of it, because -- Bill, you get to the second major piece.

An annual physical is huge, coupled with some type of a wellness fitness program, and so, that's the -- that's the second part of this -- of this whole chapter, and that gets to, you know, the ongoing issue of needing to do both things.

And so, you know, if you ask the question again, it's some percentage of those departments that are doing the annual physicals, and there are some departments that are doing annual fitness assessments that aren't doing annual physicals, because they at least are -- they've at least gotten their -- for lack of a better word, they've dipped their toe into the

water of moving towards a comprehensive wellness fitness program but have at least started with the annual fitness assessment and then placed it on the individual firefighter to ensure their own -- you know, their own physical is conducted on an annual basis.

MR. LEVINSON: Let me just jump in, just so that everybody's clear. What's written here in the physical performance requirements does not specify an annual or any periodicity for a fitness assessment.

MR. TOBIA: This is Matt Tobia. I don't know that that necessarily is a bad thing or a good thing. You're just asking a question about the number of departments that are actually doing it.

If I could, just one more point. I think Pat brings up an excellent point, which is the cost.

The other major issue that we're facing is accessibility, and that's why -- you know, that's why I think that there's a big effort to try to engage public health officers who are working in rural communities, delivering primary health care in rural communities, to engage them to be able to do the same thing for emergency responders, because the other major issue is

accessibility. Communities of 5,000 or less are usually very far apart and far from population centers.

MR. INGRAM: So, are we talking about county health departments here?

MR. TOBIA: Yeah, you're potentially talking about public health, you know, officers.

MR. INGRAM: We have county health departments in nearly every county in the United States.

MR. TOBIA: Correct.

MR. INGRAM: I know that they're pretty well taxed now just to provide the services that they're providing, so one more thing added on.

MR. TOBIA: Correct. But one of the things that we have identified is that they have the accessibility. They oftentimes have the desire, too. They don't necessarily have the training to deliver the physical that's needed for the provider, because they're uneducated about what that means.

MR. INGRAM: Well, if a criteria could be provided, that would be a possibility, and those are available everywhere.

MR. LEVINSON: And that's something that we

could add as a non-mandatory appendix that provides some guidance on what this would look like, including a range of different options.

So, it's not uncommon for us to put in, you know, here's three different approaches that you could use to get this.

MR. INGRAM: Lots of good ideas.

Bill.

MR. TROUP: What Matt was saying about -- same thing about the health and fitness program, because there may not be resources to run a health and fitness program in a smaller department or, you know, someone who doesn't have -- you know, maybe we need to provide the information and guidance -- I know we have the wellness fitness program and a lot of other things, but that may not be reachable down in the small, you know, 2,000 population, 15-person fire department. How would they accomplish that? That may be something we could also dovetail, is provide guidance on that, too.

MR. INGRAM: Okay. So, no matter which way we go, we would want to have those parameters for the fitness test that's already in NFPA, and we might want

to -- we might have a different version of that.

MR. MORRISON: Just to add onto that, on the fitness side, if we're on that, too, that is a big component. That is a big component. That is something we would want to look at.

But probably the largest cost in some of your larger departments, even your middle-size departments, are your workers comp cost, and the workers comp costs and the injury rate that we're seeing in the fire service, because of the job and because of -- you know, you go back and you look at the fitness, you go back and you look at the medical screening, but that is a huge cost to every municipality.

I love that we have economists in here. I can say they'll deal with it.

But you know, that is a cost that we are going to have to put up, because that is a huge piece that a lot of municipalities are faced with. How do I get my workers comp under control?

The problem with our death rate is it's -- you know, fires are going down, but our death rate is staying the same, and you know, we're just -- you know,

it's amazing, and the injuries are again staying the same.

So, a lot of these things tie into injury prevention, which ties into another cost item that we'll have to put on the table to take a look at.

MR. TOBIA: Can I ask a question for education purposes, Andy? And I apologize for not knowing this as well as I should, but hazardous materials technicians get an annual hazardous materials physical that is centric to being potentially exposed to hazardous events.

Is that covered under the OSHA hazardous materials regulations?

MR. LEVINSON: Yes. So, the costs for that are covered.

So, for example, you could say 50 percent of all firefighters have hazmat training and get a hazmat medical and that the add-on costs to go above and beyond what's already in a baseline hazmat medical to get to a firefighter medical evaluation is, you know, only 10 percent of what a full, you know, NFPA medical would be.

So, yes, that is one approach.

Yes, when we talked about benefits, you know, doing physical -- you know, if doing physical ability testing in some way helps assure that you're getting people who are healthier in the wellness/fitness cost to offset injury costs from sprains and strains and other sorts of things, there are benefits to offset.

And this is, quite honestly, you know, a challenge that we always face as we're writing regulations. Where do you draw the lines?

And if you say that the current practice is acceptable, then you're also accepting the current injuries that go along with not doing medicals or not doing physical ability assessments or -- you know, and so, you know, even if you're not explicitly saying that, you're implicitly saying it's okay that these people are going to die from heart attacks, because we don't want to recommend medical evaluations for this population, because it costs too much money.

MR. INGRAM: I want to add on to your point just a little bit, and I thought we were almost done with this conversation, but not only fatality data that

we're looking for but incident data and incident rate data would be very helpful.

So, we have -- especially now with hospitalizations added to the OSHA record keeping, that might be interesting information to have.

MR. TOBIA: Interestingly, to your point, there's actually been a very substantial but not yet successful effort to get the -- to get one question added to the admission data for people coming in, because we would like to be able to answer that.

We in the fire service community would like to be able to answer that question that you're asking right now. The challenge is that if you're a volunteer firefighter and you go to the hospital and they say what's your occupation, you will say what your occupation is, when in reality, the precipitating event was the fact that you were a firefighter, and so, we have a difficult time being able to quantify exactly what you want to be able to quantify, and we are working -- public health folks are working -- and NIOSH folks are -- you know, are killing themselves to try to get the hospital industry to agree to add one question

to the -- the list of questions that get asked.

MR. INGRAM: It goes by NAICS code.

MR. TOBIA: That's exactly right.

MR. INGRAM: So, we had a conversation about that last week during our full NACOSH meeting for temporary workers, and maybe we could carry that on over to this.

MR. TOBIA: The question is, are you a firefighter?

That's the question, because then we have the opportunity to collect that data.

MR. INGRAM: Or emergency responder.

MR. TOBIA: Or emergency responder of some kind, exactly.

MR. WARREN: Just curious, Matt. This is Bill Warren. I was just curious. Is that data broken down by state, also, or is a cumulative of the whole country? It would be good to see if we could see that broken down state by state.

MR. TOBIA: We could if we were able to capture that data about what they're actually doing. Are they an emergency responder? Right now we don't do

that. We could do it for career firefighters, because they say what's your occupation? I'm a firefighter.

For volunteer firefighters, who comprise 70 percent of our total population, we don't yet know that, which is what we're working towards, and there's public health doctors at Drexel University that are spearheading that effort in their -- in that public health program.

That's one of the major challenges that we face in terms of being able to quantify that issue.

MR. FONTENOT: This is Kenn Fontenot.

The data that we're not collecting in this because of the emerging cancer issue is -- particularly in a volunteer service, when they do a -- when the coroner is signing the paperwork -- the death certificate -- they ask for your primary job, and if you're a volunteer firefighter that doesn't reflect if they died of cancer.

So, the rates there are really skewed. We know that, and we also know that the career guys who are retired out and they're dying of cancer wasn't identified during their career is skewing the cancer

issue, too.

So, that's another reason for those questions being added to admissions and death certificates, as well.

MR. INGRAM: It's a great point, and that's something that we might be able to help influence within NACOSH. Anne Soiza is our chairperson in NACOSH sitting over there, and so, I'm going to -- can I ask Anne a question since she's -- Anne, would you please come to the microphone and maybe talk a little bit about the possibility of us influencing the questionnaire that folks have to answer with OSHA when there is a hospitalization on the record keeping.

MS. SOIZA: Oh, okay,

MR. INGRAM: Yeah. I knew I'd get to a point where you'd see what I meant.

MS. SOIZA: It's okay.

MR. INGRAM: So, if there was a question on the OSHA questionnaire that we had to answer when people were admitted to the hospital about participating in emergency response, it seems like that might be a simple solution.

MS. SOIZA: I think that it's perfectly within the role that NACOSH has to -- if the committee wants to bring forward -- we don't have to wait until this work is done.

We can bring it up at the next NACOSH meeting as a motion to encourage OSHA to assure that, in the questions that are asked on the form that's being filled out when hospitalizations and amputations, losses of eyes and, you know, fatalities occur, to capture the role of the decedent or the victim or the injured party, as it were.

So, in state plans and in OSHA, we're working on a form. When we get the calls that are now -- all of those are reportable across the United States, and there's a whole series of questions, right, Andy?

MR. LEVINSON: I believe so.

MS. SOIZA: Yes. I mean, Washington has its own form, but I'm sure that every state has done its thing that are collecting the data so far, and I know OSHA is working on -- we're in the mode of changing that form to try to collect the best information, and last week at the full NACOSH meeting, we made a motion

to encourage the collection of certain types of data in that inquiry, and I think that NACOSH could make a motion, no problem.

You and Lamont could make it on behalf of this group if you wanted to, to encourage OSHA to incorporate the identification of firefighting contributions to --

MR. INGRAM: Or emergency responders in general.

MS. SOIZA: I think that's perfectly legitimate, and we can do that.

MR. INGRAM: So, I'll fill Lamont in on that, and we will make that -- so, we're talking about making a suggestion to full NACOSH to suggest to OSHA to collect that data.

MS. SOIZA: And it doesn't have to, you know, wait for years. It could be just at the next meeting. We could just take a half-an-hour and do it.

MR. INGRAM: So, we'll -- I know that minutes are being captured. So, we'll make sure that that item is captured as an action item in the meeting minutes today for us to make that suggestion.

So, that might --

MS. SOIZA: We're doing all sorts of things when we're collecting those incidents in the states and in Federal OSHA, we capture, you know, who the employer is, how many people were hurt, what the incident was. So, there's quite a bit of stuff collected already.

MR. INGRAM: How long of service that they've had with the company. Okay.

MR. MORRISON: There is a special committee that meets, and these fields are protected, and they are not -- I mean, it's not just -- we need all the support we can. This is something that would help us immensely. Getting better data is what we're trying to do here, better understand where the injuries -- better understand where the cancers are, better understand that.

But this was -- this was the hardest thing, and we failed in the -- there's an annual meeting. People, you know, meet on the -- on the -- it's medical advisory and it's a selected committee on here.

But anything that we can do to push that, we can bring it back, and we can at least get that out to

the people that need to know.

MR. TOBIA: This is Matt Tobia. There's two real issues at play.

One is the one that I think you were speaking to, ma'am, which is relating to workplace-related injuries and getting data -- because OSHA is focused on workplace-related injuries.

So, if somebody comes to the hospital and they have, you know, a severed arm, that's going to trigger this series of questions.

If somebody comes to the hospital and they're having chest pain and they ask them their occupation, it won't automatically trigger the question about -- you know, for non-traumatic events that aren't automatically perceived as workplace injury, you know, workplace events, that's where we need to capture that additional data.

MR. INGRAM: Okay.

MR. TOBIA: What you all are talking about can definitely help us, no question about it.

MR. INGRAM: Okay.

MR. TOBIA: In addition to that, there is a

bigger issue that Pat's talking about, which is the entire hospital admission process for anybody coming in who has a chief complaint.

MR. INGRAM: So, just to clarify this action item -- well, let me ask you this. I've resisted asking anyone to form another subcommittee, but could I ask a few of you experts to have a couple of conversations before the next NACOSH meeting and provide some pertinent questions or some suggestions for a motion to full NACOSH on this as far as questions to be asked on the OSHA report for hospitalization or amputation. Would that be okay?

MR. TOBIA: Sure.

MR. INGRAM: So, would you chair that? Okay. So, Matt is going to chair it.

Anybody else want to volunteer for that work? Okay. Bill Warren. Anybody else? Okay. Grady and Victor. Okay. So, that's a good subcommittee of experts.

MS. TRAHAN: You're talking specifically about the reporting requirement --

MR. INGRAM: -- for OSHA, because this is an

OSHA group.

MS. TRAHAN: -- for OSHA --

MR. INGRAM: Yeah.

MS. TRAHAN: -- when someone is hospitalized.

MR. INGRAM: Hospitalized or has an amputation. That's the new reporting guidelines that are in place now. So, if a person is hospitalized or has an amputation -- and it could just be the tip of a finger, just to be clear. It doesn't have to be a full appendage. Something that won't grow back is the way I usually describe it. So, it can be the tip of a finger.

MS. TRAHAN: And this reporting is done by the employer. The obligation is on the employer.

MR. INGRAM: That's an obligation by the employer.

MS. TRAHAN: So, wouldn't the information about the incident be collected already?

MR. INGRAM: It would not necessarily identify them as an emergency responder. That's the whole point.

MR. LEVINSON: The employer would be

identified as an emergency responder. So, if you would look at -- in the case of the OSHA form, you would be able to see the NAICS code for the employer. So, it would be either a career fire department or a volunteer fire department, if they were covered in the state.

So, that's who would be doing the reporting, as opposed to the hospital piece, where there's a lot of folks who aren't reporting, and so, I think that this is probably not as big a deal for the OSHA reporting as it is for general surveillance, which I think is where Matt is headed.

MR. TOBIA: That's correct. The predicating question that you had asked was how many -- you know, how many people are having -- how many firefighters are having non-fatal events on an annual basis, and the response to that is, it's tough to know, because oftentimes, when they go to the hospital, they don't identify themselves as emergency responders, and what we're trying to do is just -- we're trying to fix that, which Pat correctly identifies as roughly equivalent to pushing a noodle up a mountain because of the resistance to add data fields to an already complex set

of data.

MR. LEVINSON: Let me jump back to some OSHA requirements for rulemaking. The most important thing to get out of this is the committee's recommendation about which populations need what types of medical evaluations and what should be in it.

We are required, in the course of doing rulemaking, to use best available information and to have substantial information, but we're not required to have certainty.

So, our folks will estimate and model based on whatever data NFPA has or U.S. Fire Administration or anybody else has for the economic modeling for costs and benefits, but what, really, this committee can provide the best recommendation on is who needs to get medical evaluations, what's the periodicity of that medical evaluation, and what needs to be the content of that medical evaluation, and you can have different requirements.

So, it could be one thing for interior firefighting and a separate thing for other technical rescue and a third thing for skilled support, and it

can be different periodicities and it can be different content, but that's ultimately what we need out of this committee, is a recommendation about what you think is appropriate as a medical evaluation, and again, periodicity and content and group.

And you can do that in lots of different combinations and permutations as you deem appropriate, but what we want to get to is a recommendation from the committee that you think is adequately and appropriately protective for the types of hazards that these folks are facing and what's necessary to do their jobs in a safe way.

MR. INGRAM: Chris.

MS. TRAHAN: Chris Trahan. I'd volunteer work group two to take on those questions.

MR. INGRAM: Okay.

MR. TOBIA: I was about to offer that the group that you had identified to do the other thing could do that, as well.

MR. INGRAM: Okay. Does everyone agree to that?

MR. FONTENOT: I like what Andy just said, and

I was listening very intently when you said it. He had different layers of medical requirements for different functions, and that makes absolute sense, particularly when it gets into the volunteer group, where you may have interior people and you'll have, you know, your support people.

And I think it will make it more feasible to do if we do delineate them, and I really, really like that idea if we can come up with a requirement for your support people, the folks that are going to bring the water, bring the Gatorade, maybe pump the truck, and not do interior firefighting, and I know it goes back to job-related skills, but that would probably solve some of the major issues we have run up against.

MR. INGRAM: That makes sense to me. Does that make sense to everybody else?

MR. TOBIA: This is Matt Tobia.

Chris, if you all wanted to focus on the support services, support -- skilled support services personnel, and we could --

MS. TRAHAN: Well, I think the skilled support personnel outside of the ESO employment.

MR. TOBIA: Right. Outside of ESO.

MS. TRAHAN: Not the truck guy.

MR. TOBIA: My group wouldn't perhaps be focusing on the ESOs. Great.

MS. TRAHAN: Yes, I agree.

MR. TOBIA: Mr. Chair, if you're okay with that -- so, my work group will focus on meeting the -- answering these three questions for ESOs and Chris' group would work on skilled support organizations outside of ESOs.

MS. TRAHAN: Yeah. What I wrote down from what Andy said, he's looking for periodicity, content, by the different groups. So, ours would only be non-ESO personnel who are skilled support personnel.

MR. TOBIA: Right. And ours would cover all ESOs.

MR. LEVINSON: Let me suggest that, at this point, it's probably not necessary to worry about writing it in a way that is consistent with regulatory text, and if there was just a table of here's the group, here's the periodicity, here's the content, and let the group tear that apart until they get something

that they're -- that the group is comfortable with, then we can put it into a reg text type of format at some later time.

MS. TRAHAN: Just to add to that, wouldn't that be good once the -- the service is provided --

MR. LEVINSON: The range and type of services?

MS. TRAHAN: The range and the type of -- just follow that format.

MR. TOBIA: As well as training and certification.

MS. TRAHAN: Yeah. But you know, when you think about the different categories that are laid out here, it might be good to discuss those categories.

MR. FONTENOT: This is Kenn again.

I made some notes earlier this morning, and we've kind of stumbled on some of the note I made about -- we do have a skilled support worker definition, or we're going to have one, or a skilled support organization.

Being as that we're looking at different layers of medical evaluations for different folks, would it not be inappropriate to have a skilled support

responder also, and that would be a person that's doing skilled support, responding with an ESO, but not doing the necessary functions of the emergency services.

That would be support people on an emergency, the ones that do the rehab. They do the SEBA refills. They do all of the jobs that need to be done, because -- and have -- you know, have that distinction, as well, because if you're doing medical -- a 1582 medical for a person that's on the scene but all they're going to do is support work, it doesn't seem like it's a good -- a good bang for your buck.

MR. LEVINSON: So, what I would say is, typically when we do an OSHA regulation, you're looking at folks who are risk, who are exposed to a hazard and at risk of injury. So, for example, the folks that are doing -- running the canteen or, you know, doing things where they're not likely to get hurt might not be covered by this standard, you know, whereas somebody doing exterior fire operations might be.

So, I think we need to look at some of the folks that you think might be in this, might be in a safe area, and may or may not be covered by the

standard.

MR. FONTENOT: But there's still that population, and it's probably a very good percentage of them, that are line-of-duty deaths due to coronaries.

If you look at the ones that have heart attacks in that area, a lot of times they're support people, traffic police.

MR. LEVINSON: I would say traffic police are not -- they're in a hazard area. They are exposed to trucks, cars that are passing by. That's a hazard. If you're providing medical support services during rehab, I don't know the extent to which you're exposed to a hazard.

MR. FONTENOT: The gentleman the other day that was doing CPR on somebody who had passed away -- that would be the case in point. He had a coronary while he's providing medical support.

MR. LEVINSON: I think he's an emergency medical responder. I don't think that's a support function. I think he's providing emergency response.

MR. TOBIA: And I think, Andy, to your point, if I could, I think that the, you know, folks that are

-- I think that we can -- we can work within the group to identify, you know, who really truly -- and we can work -- Chris and I can work on support services, but I think -- I think the draft text that we saw defined a support services responder.

I think that the draft definition that we saw earlier today --

MS. TRAHAN: We did, but during the course of the conversation, we changed that to --

MR. TOBIA: Right. Skilled support worker. I think that's a language issue.

I think we could all point to the rare instances where individuals are playing some supporting role and have a cardiac-related event, which I think is probably more consistent with all of the other risk factors that they had, as opposed to the proximate action that they were doing, as opposed to what we're -- what I think we're looking at, which is proximate action. In other words, engaging in the provision of emergency services, you know.

So, I think we're in a position where we can capture all of that.

MR. FONTENOT: Thank you.

MR. INGRAM: Okay.

MS. SHORTALL: I'd like to ask a procedural question about what will be taken forward to NACOSH, and maybe I could ask Anne if she could come to the microphone and I could ask that procedural question.

Anne, at the NACOSH meeting, NACOSH decided, in response to the new initiative, employers being required to call in hospitalizations and amputations. Additional questions, additional information you would like OSHA to elicit during those phone conversations -- is that what NACOSH would like to provide a recommendation to the agency about?

MS. SOIZA: So, last week, the recommendation that we made had to do with temporary workers, if I'm not mistaken. That was a whole week ago. I've flown 6,000 miles since then.

MS. SHORTALL: This was during -- after the presentation about hospitalization and amputations.

MS. SOIZA: What we did was we moved to have -- we moved a motion forward, a recommendation to Federal OSHA and to NIOSH to increase the data

collection to identify temporary workers.

Rick and Lamont, can you help me?

So, what I stated a few minutes ago was that there is nothing stopping NACOSH from making another recommendation to help this committee succeed by figuring out what data you might want collected, not that it can be, you know, not with certainty, but data that you would like to have collected, and all we do is we make a recommendation to OSHA and NIOSH about the data that you need to make better decisions for the purposes of your mission.

MS. SHORTALL: And what were you hoping -- what were you hoping that that data would be eventually captured in? Did you mention things like the phone call, OSHA 400, other types of forms and initiatives that that data could be worked into?

MS. SOIZA: Well, my recommendation would be that this committee not jump to the solution set but just to present the issue, which is that you need data on X, Y, and Z. For example, based on this conversation, the data to somehow also be collected by OSHA when a report of injury is made that would ask the

question, was this during an emergency response, was the worker in an emergency response mode, or something like that.

The motion should take into account something around that issue, but whether that's when the phone call is made to OSHA or the state plan state to report the hospitalization or at some later point in time, like in the -- there is a system when we do inspections where we collect all sorts of data in there that we could maybe identify, but I don't want to jump to the solution. Let's just present what the need is.

MR. INGRAM: Thank you, Sarah.

So, we had a couple of different conversations going on there.

MS. SOIZA: Yes, we did.

MR. INGRAM: So, we'll circle back, and if I can just beg everybody's patience just for a minute -- so, the suggestion that I had made was, just as a step in the right direction, to suggest to OSHA that they ask a question about whether or not employee or worker was responding in an emergency response, plain and simple, and so, whether they're employed or a

volunteer, the employer might report it, they might not.

MR. LEVINSON: So, let me jump back in. I think we've gone off track a little bit.

So, my understanding of -- last week in NACOSH -- was the reason for asking about temp workers was because the OSHA data was not adequately reflecting the injuries to temp workers.

In this case, if the fire department, whether it was career or volunteer, was reporting, we would know that they were emergency responders. The only group that you might get by asking -- and we would know that by the NAICS code of the employer already.

The only additional information that you might get out of asking OSHA to gather additional information is if you had skilled support workers who were injured during an emergency event that we could identify that they were injured during an emergency event and not during their normal skilled support types of activities, and that was not at all the issue that Matt had raised about it's hard to answer some of these questions about the emergency responder population,

because the data is not as well developed as we would like, and I don't think that you're going to get what Matt was asking for out of asking OSHA to do this additional data collection.

MR. INGRAM: I agree with that.

MR. LEVINSON: Okay.

MR. INGRAM: Chris, did you have a suggestion?

MS. TRAHAN: I was just going to add that you would get the fire brigade type situation, but that's not the question that Matt had raised either.

MR. TOBIA: I would actually just say, on the face of it, I think there's value in getting that data, because if there are support -- skilled support services personnel who get injured while on an emergency response, no one is capturing that right now, and certainly that is valuable, okay?

So, I do think there actually would be value in asking that question, because you know, a person who is a skilled support worker who gets injured on an emergency scene would not otherwise necessarily get captured on data we would want. So, I think that's valuable.

The bigger issue that OSHA -- and I don't even know if there's any nexus whatsoever -- is that if OSHA can lend its voice to the discussion of more broadly capturing data for, particularly, volunteer emergency responders who experience sudden illness requiring hospitalization, that there would be a mechanism by which we could capture that in a not as of yet accepted data set, that that would be helpful.

I don't know if OSHA is even in a position to lend their voice to that discussion.

MR. LEVINSON: Let me tell you, we've got no pull with those folks who are doing those medical records, because we have other -- forget about this group. We have some larger just occupational impact of injuries, and you know, because the problem is that everybody and their mother wants, in the electronic medical record, to have just one more question.

MR. TOBIA: Of course. And it may be a moot point.

MR. LEVINSON: I think NIOSH has had the same issue and CDC has had this issue, and that's one of the reasons there are some very high firewalls around what

questions are asked at hospitalization.

MR. TOBIA: Mr. Chair, I don't want to run either one of you down this rabbit hole.

My intent was to simply identify for you one of the challenges associated with it.

I think that the two committees -- the two sub-work groups that you've identified, I think, will be very helpful for this subcommittee.

MR. INGRAM: I agree with that, as well.

Go ahead, Anne.

MS. SOIZA: Nonetheless, speaking now not as NACOSH chair but kind of as the head of Washington's program -- and Bill, feel free to jump in -- I think that anytime there is an opportunity for data to be collected that is not -- I think it's a missed opportunity if we are not doing so.

I think that the members of OSHPA would be more than happy to entertain a very specific request from this group. Whether or not OSHA will or won't, I'm sure they will at least entertain it, right?

I think that there still is merit to pondering whether you want to make a recommendation that we can

vote on at NACOSH so that we can forward it to -- we could make a NACOSH recommendation to not only Federal OSHA and HHS, NIOSH, CDC, but also carrying that forward to OSHPA, state plan states, because we do collect a lot of data, and many of the state plan states actually do have jurisdiction over the state, local, city jurisdictions which have the primary workforce that you are all concerned with.

You know, we only cover half the country. The other half of the country -- I don't know what we'll do about that, but it's a missed opportunity if we don't at least grab -- we won't probably add 15 questions, but I think that if there was one or two pieces of data that could be added to our collection, I think that we would consider it.

So, don't close the door on a motion, I'm just saying.

MR. MORRISON: I agree with Anne. I think we could get the information to this body and at least have some further discussion. I don't think we -- I don't think we've really pinpointed what we're actually trying to say here, and we will get that information,

but it really does tie into everything else.

If you track it all the way back, it is the annual medicals, it is the physicals, but it gives us that big data that we're missing that can help us on one end. If we don't have it, we don't know we have an issue. We don't know what we don't know in this case.

MS. SHORTALL: Matt, you ended up accomplishing two goals. You talked about what you'd get for them and also what you could do to make your own standard better. So, I think you've accomplished quite a bit walking down your rabbit hole.

But I should add that, if you do a recommendation to NACOSH, the recommendation will then be discussed and deliberated by NACOSH. They could change it. They could accept it. They could vote on it and make it to OSHA, which, of course, can, once again, decide they want to do something or not do something, but hopefully NACOSH will not simply be rubberstamping your recommendation to them.

MS. SOIZA: Unless we think it's good. We'll certain discuss it.

MR. INGRAM: So, would you join that work

group. Do you mind? I know you have a full plate, but --

MS. SOIZA: I could try, yes.

I'll give you my contact information, Matt.

MR. INGRAM: For that portion of it.

Grady.

Mr. DeVILBISS: Grady DeVilbiss.

Just for a matter of semantics and clarification, though, when we're talking about the form and as we're getting there, I know we have several terms that we've been using, you know, here, and I think Mr. Chairman used "emergency response community" that we would be looking at, maybe, on that form, or if we go down the rabbit hole with the hospitals.

Just so we're all using the same thing, we don't have to go back and we didn't capture something, because by our definitions that this subcommittee is going to recommend that we miss a group.

Does that make sense?

So, just a generic -- a generic title that we're going to put on here, so we're all comfortable with and we don't get hung up on that, and y'all can

work that out.

MR. INGRAM: Do you have anything else, Anne?

MS. SOIZA: I always have something else, but no, not right now.

MR. INGRAM: Thank you.

So, we have a subcommittee formed, and they'll have two basic tasks. One, to suggest a couple of -- one or two questions for -- to be added to the hospitalization or amputation reporting, and another to work on Andy's suggestion about the medical evaluations and physicals, period, content, language, etcetera.

Anything else on medical at this time? We have really worked on this hard. It's a really great discussion.

Lamont's been taking it easy, because I told him I'd take this one, and he was going to take the next one, which was going to be harder. So, we've got to put Lamont to work.

Anybody else?

MR. BYRD: At 2:35, we'll reconvene.

(Recess.)

MR. BYRD: Let's reconvene.

MS. SHORTALL: Mr. Chair, at this time, I'd like to enter into the record as Exhibit 8 OSHA Letters of Interpretation on Training Requirements for Emergency Responders, dated October 2, 1991; March 4, 1993; and November 7, 2008.

Okay BYRD: Okay. Thank you.

Rick, you wanted to add --

Mr. INGRAM: We wanted to let the minutes reflect that Pat Morrison is going to join Matt Tobia's work group, subgroup.

MR. BYRD: Okay. Thank you.

We've had, I think, a pretty robust discussion about at least certain sections of paragraph G and we had some discussion on paragraph E, but we sort of skipped over risk management plan, paragraph F.

So, I'd like to circle back to have a discussion there, at least tee this up so that we could have a discussion, and just to introduce this, as currently drafted, the section on risk management plans envisions a written document that will be the basis -- become the basis for training, standard operating procedures, response equipment, personal protective

clothing and equipment, and operations/incident command decisions at actual events.

Is this approach to risk management appropriate? Is this approach appropriate and flexible enough for small fire departments, both career and volunteer, and industrial emergency service organizations?

Is more detail needed to assure that the ESOs have adequately identified risk and developed adequate plans to minimize or eliminate risk? If so, what additional elements should be added to the plan?

That's a lot, but let's, you know, I guess, carve it up in some pieces and try to have a discussion on that.

MR. MORRISON: Pat Morrison. Can I just ask, why are we calling it risk management? Maybe that's a term that we use here or that's going to be used here, but boy, that term always -- it always gets -- you know, there's a risk management team in all these counties and cities.

It's more -- it's not really a fire service term. Maybe I'm wrong in this, but I don't know. Is

there -- is that just an accepted --

MR. BYRD: I'm not sure.

Bill?

MR. WARREN: This is Bill Warren. I think that in some of the firefighting -- particularly wild land firefighting element -- there is an element for a risk management plan that they do put together. So, I think it's in part of their -- for the wild land firefighting, there is a risk management plan.

I think this kind of coincides with that, as I understood it.

MR. MORRISON: I just didn't know if it was -- we have like incident action plans. We have, you know, something that relates more to that. I just didn't know if this -- I didn't know if NFPA or anybody else -- if we use that risk management, do we really -- is that really what the -- the lead on this is?

MR. TOBIA: This is Matt Tobia. The only -- Pat, I would just offer for this -- to me, this looks like something similar to what you would -- to meet the requirements of NFPA 1500. In other words, every organization has to have a risk management plan that

addresses these various functions. I think that's pretty consistent --

MR. MORRISON: Okay.

MR. TOBIA: Just looking at it, it looks very consistent with the NFPA requirement, NFPA 1500 requirement for organizations to have risk management plans in place.

MR. MORRISON: Yeah. It wasn't the plan, it was just the title, but that's title. If the title -- I didn't know --

MR. TOBIA: The only thing I would offer for this -- and Andy, you may have already addressed it, but the only thing I would offer is the periodic updating and review of it.

As it's currently written, I didn't notice -- I noticed the establishment of the plan. I didn't notice language that maybe I missed, but I didn't notice language that addressed with what periodicity it had to be updated.

If we could just add something in about that periodicity with which it gets updated and reviewed, that would be great.

MR. LEVINSON: I think that's an excellent point. Do you have a recommendation for -- or does anybody know if there's an NFPA recommended in 1500 -- is it every three years or something like that? Or five years.

MR. WILLITTE: Ken Willitte. I'm not aware, but I'll check into it and report back.

MR. BYRD: Or when the scope of the activities would change, I guess you would have to --

MR. TOBIA: Mr. Chair, absolutely. If you have a change in your scope of responsibilities, it should be reevaluated, and then otherwise with some regularity. I don't know if it's a five-year plan or a -- I mean a five-year periodicity or a three-year. I want to say I thought it was five, but I could be wrong.

MR. BYRD: Bill Hamilton.

MR. HAMILTON: Bill Hamilton. At the very end of the document, pretty much, page 29, program evaluation, we suggested that -- evaluate the adequacy and effectiveness of the entire plan, entire emergency response and preparedness plan, at least annually.

So, the risk management component would be part of that. Again, if there was an issue, you know, as we noted, it should be changed, but we have it there. We can certainly change that, whatever your recommendation is, but I mean, we're looking at an overall -- taking a look at everything at least once a year to make sure we're still on track.

MR. BYRD: Rick.

MR. INGRAM: I have a question. So, one of the reasons we're here, from what I understand, is because of the event that occurred in the City of West, Texas, and does this section speak to the local firefighters or emergency responders in the typical events or the potential scenarios that they might get into in their communities, or am I off track here?

Let me know if I'm off track, but it seems to me that this is speaking to that and how are we identifying -- I think an emergency response plan -- writing, you know, emergency response plans for corporations, we have to consider the different scenarios that we might be facing.

MR. HAMILTON: I believe part of that is the

jurisdiction -- community risk assessment, jurisdictional risk assessment, vulnerability assessment, as part of the component of the plan, I mean the whole thing. We're looking at the whole thing as a program standard of following through. Am I missing the question?

MR. INGRAM: No, you're doing fine. I hope I'm on track here, because I'm concerned about -- if we're -- if we're doing hazard identification, I'm looking at number iia, hazard identification, actual and potential hazards.

If emergency responders were looking at actual and potential hazards, would they not be looking at potential scenarios within a community or within a county, and I'm really looking at kind of the grassroots level, and are we -- is this where we address that?

MR. WILLITTE: Rick, to your question -- this is Ken Willitte, and I think what we've laid out here would be a tool to do exactly as you laid out, that at the local level, when the emergency response organization is doing their hazard identification, if

they see ammonium nitrate being stored, that should definitely fall under hazard identification, and then the next step is they should say if we have an emergency involving that, what are we going to do, and build a response against that.

So, to your point, this is a tool to address that gap.

MR. INGRAM: It seems to me the foundation of this section.

MR. LEVINSON: Right. So, I think what you're getting at and the exact point is on page 8, under E, under the establishment of emergency services provided, there's now been added, one, the community risk assessment and then, two, the community vulnerability assessment, and then, once you've done that piece, then that rolls into how do we plan for that through all of the services and equipment and the things that you're seeing in this section, and that's -- I think that was -- the third group that I think is meeting in January is going to flesh out more what that means.

But I think you're spot on, Rick, that that's part of, you know, the goal of this, is to identify

those -- those things that people live with every day that they don't really think about enough.

MR. TOBIA: Rick, to your point, I think that's exactly right. I think that the community risk assessment gets to the West, Texas, incident. The risk management plan is more organizational risk management.

So, I think what they're talking about in the risk management plan -- talks about how do we keep, you know, our organization safe, you know, and our personnel safe based on all of these other things that are going on external to the organization, but the way that I read it -- and I could be reading it completely wrong, but the way that I read it, it seems like the organizational risk -- that the risk management plan is more of an organizational focus and the delivery of emergency services, on page 8, is focused on the external things that we're going to have to deal with.

MR. LEVINSON: Right. You're defining in page 8 the -- here's what we're going to do. That leads to, here are the bad things that exist in our community.

Then you go to, okay, here's the subset of things that we are going to deal with as an emergency

response organization, and now that we've said that, then that bakes into the, here's how we're going to manage risk within our community based on the subset of things that we think we're going to do from all the bad things that exist in our community.

MR. FONTENOT: To expand on what you were saying, Rick, if this had been done at West, Texas, there is a really good chance that no offensive action would have been taken, because they would have identified the enormity of the risks and the lack of resources that are -- the resources that it would have taken to control it -- and I'm not knocking what they did, but in reality, what happened was they weren't prepared for what was going on.

But if they would have been prepared, they probably would have just said we're just going to pull away from this, get everybody out, and let it run its course, there's no way we can stop this.

So, when I read it the first time, it made perfect sense to me, and item 3 under F, "ESO may only perform the range and level of services it specifies," which pretty much says, on this one here, I'm going to

let it go, because there's nothing I can do about this. There's nothing anyone could do. To me, it helps you focus on the bad things that can happen, and it keeps you from making bad decisions in the spur of the moment. I think that's where we're trying to go.

MS. DELANEY: So, I think maybe just making sure that the two sections are linked -- I don't know if you do that through saying, you know, hazard identification based on -- in part on the community risk assessment and vulnerability assessment, so that kind of connects the two sections and puts them together.

That could be one way of --

MR. LEVINSON: So, the way that it's linked right now is through an intermediate, which is the range and level of services provided.

So, you look at the hazards in your community and then that defines the range and level of services that you provide, and then, from that, you then do your risk management plan.

So, that's kind of the A leads to B, B leads to C piece.

MS. DELANEY: Once that section gets fleshed out, maybe we'll have a better view of how it's written.

Mr. STAGNARO: This is Victor Stagnaro. I was going to bring up the same thing.

I didn't necessarily make the connection until I went back to read it, but to Matt's point and also from an internal standpoint, you look at fire stations, the things that could be a hazard within the non-emergency, which is addressed here, as well.

So, I think we need to -- I think that's where I got a little confused, and I had to go back and revisit that, and noticed it is linked, but it's really two components.

There's the non-emergency and then the emergency piece, so to make that link a little stronger would be good.

MR. TOBIA: Tragically, we have had workplace fatalities in our workplace.

In fire stations, we have had workplace fatalities, and there could perhaps be risk management controls that could be put in place to mitigate and/or

prevent them from occurring based on an assessment of the risk within an organization, simple things.

You know, we back apparatus into dark apparatus bays that you can't see because of the way the light shines on the apparatus, which makes it difficult to avoid striking somebody who is supposed to be spotting you.

So, what risk management controls could put in place? Extending the tape line out onto the apparatus. It's a very nuts-and-bolts example, but I think that this is really organization risk management, as opposed to what risks exist out in the community, which is addressed by the first part.

The only other thing I would offer is, just to the point of the question that I asked earlier, was with what frequency should it be done?

Under F on page 10, if we're, in fact, looking at respiratory protection for responders that meet the requirements of 1910-134, that should -- that would probably trigger an annual -- at a minimum, it should be an annual evaluation of that based on 1910-134.

So, if we're going to reference that, I would

just offer that we might want to add a line in this section that specifically reinforces the need to evaluate this annually, as well, which may seem redundant to the entire ERPP, but we may ultimately not arrive at a annual evaluation of the ERPP. We may change that.

But in this case, to be compliant with 1910-134, I would recommend that we make this piece an annual evaluation.

MR. BYRD: Okay. So, as we take a look at the elements of what's been proposed here under F, is this an appropriate approach to deal with risk management in the context of, you know, what you all do? Are we going down the right path looking at risk management in this way?

MR. STAGNARO: I believe it's a very good framework, yes. I think that to delineate that emergency response component based on your assessments and then look at that non-emergency response component, maybe, as opposed to lumping them together, might be a way to look at it. I'd just throw that out for thought, for discussion.

MR. BYRD: Okay. Any other thoughts or comments on that?

MS. DELANEY: Lisa Delaney. Is there a component of real time risk assessment or risk management that would be done on scene? Where would that fit?

MR. LEVINSON: Yeah. That's, I think, in the incident operations piece done by the incident commander and the incident safety officer.

MS. DELANEY: We're not going to address that here.

MR. LEVINSON: We're not there yet.

MS. DELANEY: Okay.

MR. TOBIA: You'll find that on page 25.

MS. DELANEY: Okay. The only other thing is, I didn't see a reference to other PPE. We don't talk about other PPE.

MR. LEVINSON: So, it's up in E. We just specifically pulled out the respirator one, because we have a separate respirator standard that people would also need to comply with.

MS. DELANEY: Okay.

MR. BYRD: Any other thoughts about the elements of this section? So, we think, in general, that it's an appropriate approach.

Does this offer the smaller fire departments, ESOs -- does this offer you the flexibility that you need to do what you have to do?

MR. TOBIA: A template risk management plan is going to help organizations tremendously, because most organizations do not have a dedicated health and safety officer. Most do not have somebody who's trained and knowledgeable in risk management, risk control practices.

I mean, that, unto itself, is an entire discipline. So, to the greatest that we can help people be successful by providing them a template, I think that would be great, and there are organization -- NVFC -- I believe NVFC has a template risk management plan for emergency services organizations, as does the IFC. I know that for sure.

So, there are -- there are template plans out there.

MR. LEVINSON: Are both of those available for

free to the public, or are they --

MR. TOBIA: I believe that the IFC's is available for free, yes.

MR. LEVINSON: If they are available for free and you're comfortable -- if you could send them to us so we can add them to the docket, so that we make sure that we consider them and cam provide them as examples of things that would be generally acceptable.

MR. FONTENOT: My thoughts on it, it's going to spawn a whole new cottage industry. I just think that you're going to see people that will be writing risk management plans.

MR. LEVINSON: So, you're saying OSHA creates job.

MR. FONTENOT: Yeah.

MR. WARREN: I think, Andy, Forestry also has something that's public, because it's under the Department of Forestry, and I think they have -- for their wild land firefighting, they do have a template kind of plan.

MR. LEVINSON: Great.

MR. FONTENOT: This is Kenn again. To answer

your question, yes, it gives a lot of flexibility to the department.

It gives you the ability to look down a checklist and see, have I done my homework, and it probably, if it's done correctly, would help you focus on what you have to control and how are you going to control it, or if you can, and I really kind of like this format, because it gives you something concrete to work with.

MR. BYRD: Anne, did you have a comment?

MS. SOIZA: On the question of the actual terminology "risk management" is what I'm going to be speaking to.

Risk management, as many of us know, is a discipline -- it's a whole world. It's not -- it's a discipline and it's multiple disciplines, right? There's workers comp risk management. There's tort risk management.

And so, I would put forward to you some caution as to strongly consider if that's really the term you want to use for the title of this, because as Kenn said, this will produce a whole new cottage

industry around -- you know, who want to help fire departments come up with this stuff, and there are -- most cities and counties and state governments have a whole risk management arm, and they're going to wonder, what, we don't cover this, and then it's going to -- because the term is like a generic term, risk management, there's going to be a lot of confusion, and so, I'm not -- I'm wondering if maybe you might want to ponder a different terminology for the title of the program.

MR. BYRD: Do you have any suggestions? Not to put you on the spot.

MS. SOIZA: Incident prevention program. It's not just about the emergency. It lists out non-emergency incidents, as well. No, I didn't really -- you caught me off -- I'm just saying that I have risk managers who -- that's all they do, you know, every day, day in and day out, and this would be a complete surprise to them.

This would not -- they would not consider this in their bucket of expertise.

So, I'm just putting that out there.

MR. BYRD: Okay.

MS. SOIZA: You would want to be careful. And I don't know what OSHA's -- you know, the document that you got it from and things like that.

MR. LEVINSON: Yeah. So --

MS. SOIZA: The title of a program can make people go down rabbit trails, and that's just my caution.

MR. LEVINSON: So, the direction that our team got was that -- which came from me -- was that we should try and stick as closely to the NFPA terminology as possible, because that is something that everybody has already agreed to, and so, I think that the things that you will see here have been lifted or stolen --

MS. SOIZA: I'm sure that's true.

MR. LEVINSON: -- from the NFPA centers, because those are concepts and terms that everybody has already agreed to.

So, we don't -- we're not necessarily invested in this particular terminology, but we have tried as much as possible to stick to what --

MS. SOIZA: I think that's a great approach,

and staff do that to me all the time, too. I get it.

So, I just wanted to put it out there that if the committee -- if this is something -- not a big deal to you and you think that the people who will be doing this work totally get what it means -- I'm just saying that the big world out there, risk management, is a whole different thing.

MR. MORRISON: That was my intent for the question, knowing that we already do risk management in the fire service. I'm looking at this document as being read by a lot of other people, and it's going to be a lot of layers outside the fire department, too, the fire service, the fire service organizations, because they're going to have to take a look at this and they're going to have to apply it to that.

So, I think that's a good discussion. If we want to keep it as risk management, but I know risk management, to me, is -- when you're looking at a big firm -- is a negative term. "Risk management" means they're not to take any risk to invest in any kind of -- you know, it is not taking the risk that "risk management" normally is driving at in a lot of bigger

departments.

It's just that whole section -- and I've worked with them, you know, my whole career. So, I just think that Anne brings up a good point, at least for discussion for us later.

We don't have to kill ourselves today over this, but I think we -- I agree with her.

MR. BYRD: Okay. Are there anymore thoughts about, you know, the issue of "risk management" versus other titles or any other issues?

MR. TROUP: Bill Troup. NFPA's risk management guide -- I forget what the number is -- how closely does this comport with the NFPA risk management guide, again looking at, you know, the A-119, you know, where an existing standard exists. Pretty close?

MR. WILLITTE: Ken Willitte. Bill, I think you're talking about NFPA 1250, which is risk management for emergency response organizations, I think. I don't know. I'd have to do a side-by-side, but I know it does reflect quite a bit of what's in 1500 and the requirements it has for a fire department to do a risk management plan.

MR. TROUP: Maybe someone will want to look at it, you know, related to this risk management practice, because I think that's used for this in the fire service. They go to the NFPA guide.

MR. BYRD: Okay. Any other thoughts? Okay. There was a suggestion earlier about periodic evaluation. Are there any other elements that, you know, you all feel may be left out of what's being -- what's been presented to us? We think it covers it pretty comprehensively.

MR. STAGNARO: If we're referring to the case that Bill mentioned later in the document, it's definitely very comprehensive, because it pretty much outlines annual in the letter "O" if I remember right.

For point of clarification, is that what we're referring to here, is saying we refer to letter "O" as far as how routine this should be evaluated?

MR. BYRD: There was a recommendation, as I recall, and a reference that, under 1910-134, there would be an annual evaluation, and later in the document, I think on page 29, it was referenced that there -- it indicated an annual evaluation then. Well,

in addition to that, are there any other elements that we think may need to be added to what's been proposed?

MR. LEVINSON: Let me suggest something for the committee's consideration, because we haven't really gotten into this and we may want to just put a pin in this, but later, as we further discuss the community risk assessment and the vulnerability assessment, maybe that's not necessarily an annual evaluation, and maybe in the evaluation part, it can be a -- is there anything that changed that would require us to add onto or change this, and if not, you know, then that community evaluation maybe goes back to a three- or a five-year evaluation.

So, did we learn anything that makes us want to go back and look, and if not, for that piece, you know, again, I think we want to try and stick as much as possible to the normal timelines that people are doing community risk assessment, because that could be a pretty substantial activity that you wouldn't want to redo every single year.

MR. INGRAM: I'd like to comment on that. I think that adding the caveat that if anything changed,

if there's any substantial changes, and then -- that makes sense, and it makes sense from a business standpoint, as well.

MR. TOBIA: And you could give some examples. New industry, new transportation hazard, you know, if suddenly, you know, heavy duty oil tankers are rolling through your rail community when it was previously just a freight community or previously just a grain community, that's obviously a new hazard and a new risk vulnerability for communities, which has already been seen significantly, so just some examples.

MR. MORRISON: That does happen. I mean, West, Texas, is a classic example. That was just a fertilizer, you know, place there, but it grew up -- the community grew up around it, too, the school, the hospital.

I mean, there are all these places that that risk became -- you know, it was just -- and that's what happens, too, which you don't even think about, because things grow up as the city starts to develop, or a town, and then all of the sudden you have these other hazards that you didn't even know where hazards,

because you didn't identify the original hazard.

MR. INGRAM: I'll take the other side of the argument now. It sounds like it makes sense, but then if you don't periodically evaluate, especially in larger cities, how are you going to know?

So, I think maybe something needs to be written in about working with the chamber of commerce or something.

I think that's a challenge for all of us, as well. So, how do these communities or counties or municipalities know if something has changed?

So, a business can spring up, and they might have lots of chemicals.

So, I've been talking to some of my friends on the environmental side, with EPA, and they have CERA Title II, Title III -- I really think that we should consider tying in with that group, because they do have reports about chemicals -- the employers have to report those.

So, I'd like to kind of ask what you all think about that.

LAPCs -- I've actually contacted the head of

the LAPC for Region VI, who happens to work for EPA. So, they're definitely interested in what we're doing.

LAPCs are boots on the ground, as well, just like you are.

MR. MORRISON: Lithium batteries. You know, this is a huge thing for us right now in the communities, because you don't even know they're being bought, and you know, big corporations are using these now to store electricity that they can buy cheaper at night and then use that electricity during the day and then do that, but these batteries -- we have no regulations, we have no -- so, that risk becomes -- we didn't even know it existed until, you know, we just had some workshops on it.

MR. BYRD: Any other thoughts or comments?

MR. WILLITTE: Ken Willitte. Following up on Rick's comment about the LAPCs and the reporting, remembering back to my LAPC days, I think when they filed their CERA Title II, you're supposed to file a copy with the fire department.

MR. LEVINSON: Yeah, CERA 311, 312, and 313.

MR. WILLITTE: But just to codify it and draw

that connection, perhaps it's worthy of noting, under either the hazard identification or someplace within what constitutes the risk management plan, that it addresses those risks identified through reporting like CERA Title III and others.

MR. BYRD: Okay. Thank you.

MR. INGRAM: Would anybody be opposed if we invite someone from one of the larger LAPC organizations to come and speak to us at some future meeting or participate in some way?

MR. DeVILBISS: EPA had a big initiative on those the last couple of years.

MR. INGRAM: I think I've got the perfect person to do that, and they're talking about forming a national organization of LAPCs right now. So, I think he might be leading that.

MR. BYRD: Yes, Chris.

MS. TRAHAN: Chris Trahan. Would it be beneficial if the group that's talking about the community assessment talked to them in lieu of -- just a question.

MR. DeVILBISS: The chairman just left, and

one of my other members just left.

MS. TRAHAN: Well, we'll table that question.

MR. INGRAM: I think that would be a good idea.

MR. BYRD: Okay. Any other thoughts or comments? Any other thoughts or comments about section F? Okay. Thanks.

MR. INGRAM: So, I think we've talked about section 7, question 7, a little bit already, about responder preparedness health and fitness. So, does everybody feel comfortable with that, that we can move on to number 8?

Number 8 is responder preparedness behavioral health and wellness program.

MS. TRAHAN: I just wonder if that's more related to the conversations that the work group is going to have?

MR. INGRAM: I think probably so. I think, actually, 7 and 8 would all be related to that. If everybody's comfortable with that, we'll allow the subgroup to review those and then bring that information back to us. Would that be okay?

And if that's the case, then we can move on to training and professional development.

MR. DeVILBISS: Something about the mule and the cart? Don't worry about the mule, just keep loading the cart.

MR. INGRAM: We have some really strong mules here.

MR. MORRISON: Before we move on, just to let you know, the comments that OSHA -- because this is even new to OSHA here, the behavioral health piece in here. Even though I think it does go back into that subgroup for us to take a look at, we are separating that from -- we are making that its own sort of category.

The behavioral health issue right now in the fire service is probably at an epidemic level as far as the issues that we're seeing on PTSD, on some suicides, on some of these programs, but it is an issue -- set aside from this group -- that we're working on separately that a lot of people collectively are putting in a lot of emphasis.

A lot of times it was just put into -- it was

kind of folded into a wellness and forgotten about, because it's not -- it's just not real sexy. People weren't really working on it.

So, I'm just letting the committee know that this is a hot area that has not been addressed in the past the way it should be addressed, and we have to have employers really recognize that -- the hidden dangers of not addressing this at a comprehensive level throughout their employment.

MR. INGRAM: Well, in that case, Pat, let me just read this question and we'll just discuss it briefly, and then we'll see if we need to move on or not.

So, this is under paragraph G, responder preparedness, behavioral health and wellness program. The draft includes a behavioral health and wellness program to address concerns about substance abuse, stress, and suicide that may be addressed with work as an emergency responder. This approach to behavioral health as a component of occupational health and safety is new to OSHA. Is this section of the draft appropriate and adequate to address these concerns?

So, that's the question. Is this appropriate and adequate? And I know just from the headlines that we're hearing these days, from California and other parts of the country where these shootings are occurring -- and we've got first responders responding to those -- it might be a different type of first responder, but -- I know we're not talking about SWAT teams here, but still, that's -- it's a lot of stress for folks, just hearing people talk about it on TV.

So, let's read through that section G real quickly.

MR. LEVINSON: Let me point out, you know, the numbers that were thrown around earlier today about, ballpark, 100 line-of-duty deaths a year, if we factor in suicides, you know, that number goes up a lot.

MR. FONTENOT: There were 104 firefighter suicides. We receive 150 calls a month on our Share The Load hotline for assistance. That's a huge number

MR. LEVINSON: And that's just within the volunteer community.

MR. FONTENOT: It's kind of open to everybody. The trouble we're having -- not trouble -- one of the

data gathering -- is a lot of times the suicides are not directly linked back to the occupation. But these are the ones that are directly linked, firefighter suicides.

There's another component that's not in here. A lot of the behavioral health issues is not job related, but it is part of the job.

Some of it -- you can't separate a lot of this -- tragically, recently, you cannot separate the suicide, whether it was job related or personal related. There's just no way to possibly do it.

There are some events that you may say are directly the trigger point, but there's so many of them, it's a blend, and you know, to just say it was job or stress related to something is probably missing a big point.

MR. STAGNARO: This is Victor Stagnaro. There are some early studies that show that firefighters are experiencing post-traumatic stress, suicide ideation, those kinds of things, very early on. Some reports are that a fire department is three to four times more likely to experience a suicide than they are a

line-of-duty death, assuming you're not considering a suicide a line-of-duty death.

But this behavioral health component is a very emergent issue in the fire service, and there's not a whole lot of data. I think there is some research that needs to be done, but I think it's something that employers absolutely must deal with and grapple with.

MR. MORRISON: Victor does a lot of work on that. He's been really a strong proponent of the programs.

Every time we go -- we've gone out to these active shooting sites and what's happening around the country, and what we find time and time again is, once we look at where were the services, are there any behavioral health services, were there any training, was there any -- is there any access to trained clinicians, and the answer is incredibly, incredibly just alarming, and it's no, no, no.

And most of the time fire departments start to put a behavioral health plan together after a disastrous event and they try to put that in place, and we just got -- this is one area that we are so far

behind as far as making sure that -- it was easy for us to do the wellness/fitness initiative, what we did on the medicals, because you can see it, you can record it, you can put all those diagnostic tests on a piece of paper, but on the -- in the mental health aspect, it was very hard for us to get our arms around that.

But we're getting more and more that we have to have these services in place, and it is management's responsibility to make sure that it's all the way from the hiring practice through the retirement.

Some of our retirees that are retiring -- if they're going to commit suicide, they're going to do it in the first two weeks, and we're finding those numbers there that are alarming, and it's just the -- you know, being present, it's the work that they're coming with, and it is a lot of other issues, Kenn, I agree, with, you know, family and everything else going on.

MR. BYRD: I have a question. In developing the behavioral health and wellness program, who would you typically have develop that type of program? What type of professional would do that?

MR. WARREN: They have professionals that do

that. They do have organizations, Lamont, that are specific to doing that. In most of the major metropolitan areas, most of the departments and cities have behavioral health EAP-type of supply.

I think as you get further away from the metro centers to the smaller communities, I do think that it becomes more limited for those behavioral health professionals that can help specifically mostly contract with some of the agencies.

MR. FONTENOT: The key is -- and I've dealt with behavioral health for a long time in the fire service. The key is to train everyone from management to peer in awareness of behavioral health, and this is something we've undertaken and worked a lot on, but I need to be able to recognize if somebody is having an issue.

You need to recognize -- help is more or less readily available. I had a rider put on our state workman's comp plan a couple years ago for mental health professional help. So, when we identify somebody, they come up and say I'm having issues, it doesn't cost them anything.

I mean, that's how strongly we felt about that issue. So, awareness and treating of the problems they're going through, I think, is paramount.

MS. DELANEY: This is Lisa Delaney. I just wanted to echo -- Kenn mentioned training, and I think this does go back to part of that risk assessment. It's not just the physical hazards that come at a risk to workers. It's the emotional component.

And if we could -- I don't know how we do that -- if we make sure that template that we're providing has concepts of training that would include psychological first aid, resiliency, as a part of that. It's not just reducing exposures to chemical X.

MR. INGRAM: And recognition. I think that would be -- we have supervisory training for drug and alcohol that would go right along with that.

MR. DeVILBISS: I know after we had Virginia Tech, it just seemed a lot of those folks came out of the woodwork, you know, so -- and actually, FEMA had a person there stationed with us at Tech. We were talking about the metropolitan versus -- I know our community services boards locally in our communities.

They have a mental health component. They've been somebody that's good to reach out with that.

But as you were talking about, the Psych 101 -- I know Red Cross has been teaching that, and some other groups.

So, there are some groups out there. It's just identifying who those are and maybe pulling them in to -- as we move forward with that.

MR. FONTENOT: We actually spend a whole day on mental health wellness with our cadets, talk about the resiliency, who they can go to, giving them assurances that there is confidentiality is a big thing. We spend a lot of time with them.

MR. STAGNARO: This is Victor Stagnaro again. I'd like to add, as well, that just as the training component needs to be included in as we reach back into other parts of the document, stress, post-traumatic stress, substance abuse will affect hypertension, diabetes, heart ailments.

So, there's also a physical effect that links back to the other discussion we were having earlier.

So, it's really weaved -- it's really a

holistic view of workers' health that needs to be evaluated and linked as we go through the document.

MR. LEVINSON: This is Andy, for the record. I've heard a bunch of supportive things. Does the reg text that's here get you what you think should be the minimum requirements for departments? And again, you can see the places where, you know, we've pulled this from the NFPA 1500 language. We've tried to mirror that as much as possible.

MR. TOBIA: This is Matt Tobia. One thing I would recommend is that the behavioral health program needs to be at least advised by a behavioral health professional. The individual managing it within the organization may not be a clinician or a provider, but there should be an oversight function by a behavioral health clinician to ensure that level of support that is necessary, and to the extent -- I would recommend that if there is peer-based -- if an organization chooses to use a peer-based program, that one component of that program be ongoing professional development for the peers.

One of the things that we've learned in the

last 30 years is that an initial training program is a great introduction to serving in the capacity as a peer counselor or a peer advocate, but without ongoing training, that those are -- those are not -- that initial training is not going to carry somebody through a 30-year length of service in -- in providing peer counseling support or peer support.

So, I think an important component that's been missing in the past that we could address here is that if an organization uses a peer-based program, that the peer-based program includes ongoing education for those who are participating.

Thank you.

MR. MORRISON: The only thing I would be that -- I think you hit -- Andy, I think you hit a lot of the big ticket items in here -- would be access to qualified services.

What we're finding out there is that, even though a department might have an employees assistance program, they are so far -- they're a reactive program and not a proactive program.

So, the services that they are providing --

they're waiting for something to happen rather than getting in and working with a department.

What we have seen out there -- it's very, very difficult to get qualified services that people need to go into counseling. You do have the confidentiality here. It's a huge thing on that.

The biggest thing that we're finding, too, is that stigma still is attached to mental health, that, you know, if I have a problem, I'm going to be perceived as not being -- but I think that's covered -- I mean, that's the training and those are the tools that they need.

I like what Lisa was saying, too, that we have to put in some of the training for the supervisors. We live with the first responders for 24 hours in most cases and we're around them. So, we know -- we know exactly what's going on in their lives, and we're the biggest enablers in some cases.

But there's got to be training, and Rick, I think early recognition is that -- we know that this is a cumulative effect.

Stress is -- it doesn't -- it's not that one

call. It couldn't be that one call, but over a period of 25 years of doing the job and seeing what you see, it adds up, and we don't recognize early on.

So, the big part in here is the training, and I think they have that.

And the other thing we have in here -- I don't know -- is from new hires all the way to the retirees -- we could probably weave that in here someplace, and then there's a big component that -- I don't even know how you put it in there, but it's the family component, also, where, you know, it does tie into the -- to the -- you know, to the individual that's actually working.

But other than that, I think you've put in -- you've done a nice basic job there, Andy, capturing -- and I like it that it's set aside, it's alone, it's not tied into -- it's not underneath, you know, something else.

The only thing I would say is assessment -- can we assess on a yearly -- I mean, there should be an assessment based on -- you know, you have services that are being used, and the problem about this is the end user is not usually surveyed, but are these services

adequate?

Are they being addressed? Are they being used? And we just don't do that. We just assume that, you know, somebody is doing this and it's done, but a lot of these places need to have some sort of evaluation on their behavioral health services they provide.

MR. INGRAM: Maybe as an addendum, a checklist or some type of a survey, a standardized format for a survey.

Chris.

MS. TRAHAN: Chris Trahan. Andy asked if this was comprehensive, and I think that prescription painkiller might be added.

I recently was made aware of an article funded by NIS that talks about this incredible spike in suicides and poisonings, particularly, I think, it's pointing to prescription painkillers, amongst white non-Hispanic males age 45 to 54.

There's been a dramatic upturn since, it looks like, 1999, between 100,000 and a half-million increase over that time period of what the rates were trending

down prior to this.

So, something's going on. I thought about this as it relates to construction workers, because in that age group, we have a lot of pain in construction workers, which may lead to problem with prescription painkillers, but I think with this population, this is perhaps a crossover to the target population of this rulemaking, so it's something to consider.

I've seen the article to Bill, so you can distribute it as you will. It's in the public domain.

MR. INGRAM: Yeah, it does mention substance abuse here in line D, but I think -- I agree.

MS. TRAHAN: I think we're seeing something going on with painkillers.

MR. INGRAM: Yeah, I agree.

MR. TOBIA: If I could, I would just recommend -- I would just recommend, in parentheses, on substance abuse, just add the words in parentheses "prescription and illegal drugs."

MR. MORRISON: We're seeing a spike in painkillers. There's no doubt about it. I mean, it's the one thing that, if you do have an injury -- and it

goes back -- you look at our injury rate, somebody gets treated, they get put on a -- you know, Vicodin, Percocet, whatever, and then they get -- you're not watching that, and then that spiral effect happens, but that becomes a legal drug that some doctor gave me to -- you know, I have to maintain that, and we're seeing that around the fire service.

MR. TOBIA: Right. And just -- if I could just dovetail on -- this is Matt Tobia. That gets into the whole economic feature, which is -- which ties back -- which shows how connected it is. A health and wellness program and annual physical and a fitness program reduce the incidence of injuries, which reduce the cost associated with workers comp, which also reduces the likelihood that an individual is going to become dependent on pain medication for their injury that never occurred.

So, to the extent that we prevent those things from ever happening in the first place, that is where the dividends -- that's where the benefits side comes into everything that we've been talking about today.

MR. INGRAM: So, I'll ask a question.

So, we have a workgroup working on -- and it's not -- be a big enough issue that we don't need to combine the two, but we have a workgroup that's going to be working on responder preparedness, medical requirements, etcetera, as per Andy's suggestion, good suggestion earlier.

Do we want to -- do you want to work on this, as well, or do we want to make a separate work group or -- or have some type of a health questionnaire or some kind of a template, or is there one that exists already that we might be able to pull in and use for discussion?

MR. TOBIA: I'll be honest with you. I mean, we can add it in, but I'll be honest with you. The way that it's written now, I'm very -- I mean, personally, I'm very comfortable with the way that it's written now. I think it really lays out a good set of expectations for an emergency services organization to follow to address -- the fact that it's in the document points to the importance of it.

MR. INGRAM: Okay.

MS. SHORTALL: Could I ask Mr. Morrison a

question? On IV, about the responder participation, the program is kept confidential -- is that -- do you consider it to be adequate to allay employee fears about participation in the program?

Is there anything else that might be needed to help employees want to voluntarily participate and not fear being involved?

MR. MORRISON: That's a great question, Sarah. We went around the country -- we did a -- we did these focus groups, and there were three things that came up.

Access to services. They didn't know where to get the services, and that was just -- the services weren't provided in there.

There was a huge thing that I talked about earlier, stigma. But one of the number one things that firefighters said is trust in confidentiality. I do not trust.

So, that's a management -- so, that's a management -- I don't trust the department. Even in New York City, you have probably one of the best behavioral health facilities there. It just happens to be right next to a firehouse. If you're going to go

use it, it's obvious that, you know, it's not your most confidential place there.

So, the trust in confidentiality was a huge issue, and if the perception is that I don't trust -- I don't trust that, we have so many employees that don't know where to go. We have started to look at -- that the department doesn't -- it provides the EAP services, but if they would rather use their own, you know, sort of services, that you have to have that included in that, also.

It's not a one-stop shop, that we have this EAP that's going to fix everybody. There are a lot of people that do not want to use a company -- I don't care where it is, not just the fire department. They don't want to go to the company. It's probably here in the Labor Department, probably has somebody you can go see.

They don't want to do that. They want to go to their own provider. How do we put that in there? I'm not too sure. But that is an option that you have to provide in some of these services that we are providing.

MS. SHORTALL: And then, very smartly, OSHA has put in language in this about "provide access to," not required, and then down below, it says "intervention available," not required.

Are those then the supplemental language that will get employees over the non-trust, and I guess the other question would be, "the program shall include" -- "shall include an assessment of alcohol and drug abuse."

Could that have any fear of chasing employees back away from a program again?

MR. MORRISON: Yes, yes, and yes.

MS. SHORTALL: What would you suggest, then?

MR. MORRISON: I'm not too sure. I mean, sometimes you try to -- you try to cast the wider net here. I don't know if we could write that.

It's not just about substance abuse. It really is about trying to get an employee that's in trouble to go to talk to a certified licensed practitioner that can help them through this crisis they're in, and if we just say -- I mean, alcohol, unfortunately, alcohol and substance abuse is a large

-- we're thinking somewhere around 30-35 percent of the fire service has that issue, which is -- you know, if you look at those numbers, that's pretty large, in there.

So, I don't know, Sarah. I understand what you're saying is how do we -- how do you make it so it doesn't feel like they're just looking at that one area of addiction as scaring somebody away.

Most of the time it's a fitness-for-duty that the fire service has to do, and that's usually -- the biggest lack that we have here is supervisor training to recognize -- how we recognize it is there's a performance change.

We know that, whatever it is, in absenteeism, what's happening on the job, and then there is -- at one point, there is a -- there is a referral that we hope most departments use that they refer the employee to get help, because their performance is going down, and then there's an actual -- you can actually mandate that, too, but that's -- I don't want to get into the weeds in here, but I don't know how we cover that up so it's more attractive.

MR. FONTENOT: I'd like to address -- part of what Pat was saying is, a lot of times, mandatory participation in something that isn't a job-ending decision doesn't work.

Now, if it's substance abuse and alcohol, that can be mandated. That's something you have to get careful or you lose your job.

When we're talking about the PTSD's and such, unless there's such a risk of job performance that they become non-functional, just having them participate in something generally doesn't work very well. You get a tremendous amount of pushback.

I saw quite a bit of it in New York after the Twin Towers -- and they talked to some of the guys in Oklahoma City, as well, and it didn't work out as well, because it wasn't maybe as well known how to do it nowadays.

So, it depends on the part of the mental wellness portion of it that we're dealing with. But definitely, if it's substance abuse and alcohol, that probably should not be an option.

MR. MORRISON: I agree with you, Kenn. I

think what we really have to do is tie this into the medical evaluation, too. We haven't really talked about that, but it's the one opportunity you have where you're with the physician, you're getting a debriefing, and it's the one area that we just shy away from. But it is that one area that we do know that there are some survey questions that could be asked, not survey questions but some assessment questions from that provider at that time, because that is part of what Matt was saying, you know, that whole sort of piece there, and you will probably have to talk about it in your subgroup, about that, because that should be in that -- that should be in that matrix.

MR. FONTENOT: Part of my de-mob plan for Katrina, we did a medical evaluation, and we provided stress management, made it available to all the people, and we had quite a number of folks that took the stress management, but it was mandated medical evaluation on the de-mob plan when they went home.

MR. TOBIA: Sarah, to your point about the issue of trust and getting -- actually getting providers to use the system, a lot of that is borne out

of the reputation of the providers themselves.

In other words, they're -- firefighters are naturally distrustful of anybody -- firefighters and emergency services providers are generally distrustful of people outside of their realm but very trustful of people inside their realm, and what you will find are individual clinicians who, over years of demonstrated commitment, have built that level of trust, and that's where you will see the success stories, and there are individuals who have been tremendously successful at breaking down some of those walls of protection that emergency services personnel build very, very well and very strongly.

MR. FONTENOT: I can address what Matt said, because I asked a lot of folks, would you rather deal with me, whom you know, or somebody you've never met? Overwhelmingly, they'd rather deal with me, and that surprised me. I totally expected the opposite, but over the years, they preferred to deal with somebody they knew than somebody coming from the outside.

MS. SHORTALL: Thank you. I appreciate it.

I just asked because when I read this over, I

thought OSHA used very carefully, well-crafted language to try and make it not seem like employees are going to be railroaded, and I just wanted to ask if that's going to be enough.

MR. BYRD: I have a question.

In terms of how these programs are implemented, when I look at 6iii, the ESO shall inform each responder of the assistance and intervention available under this program -- at what point has it been your experience that that information is conveyed to the responder?

Is it a job orientation -- or at what point in the responder's career does that happen?

MR. TOBIA: A couple of different ways. There's a variety of models.

Some -- oftentimes, it's during orientation, and then it may be periodic on an annual basis, as well as visual reminders available in the firehouse or in the emergency services organization's building where there's a -- you know, if you -- you know, if you need -- I mean, MBOC has some great marketing tools on their help line.

So, there are a variety of places, and then, oftentimes what you will see is, after a critical incident, you will see a designated supervisor at least do the outreach and make responders aware of the availability of services.

It has also been used once a performance issue is identified as a component of the total picture of getting that member back to frontline service. So, there's a variety of strategies that are employed to try to ensure that folks are aware of the resources available to them.

MR. MORRISON: Generally, I would say that you get somebody coming down from employees assistance program when you're a new hire or recruit and you get the big talk, and then that's usually basically it, and then you go into your station, and then, you know, if you do get in trouble, you know, there's this remote -- perhaps someplace that you could go to or they send you to, but in between that, it's very, very limited, and the area that is so limited is in the training of the supervisors that are responsible for their personnel to make sure that they have early signs of recognition,

but then for those supervisors, they have to know where is that safety net I can send an individual to?

They want to feel -- they want to feel that they're going to send somebody to the qualified services, and again, that goes back to the -- we have -- firefighters usually have one opportunity to talk to a counselor. That counselor, all of the sudden, is more intrigued about the job that we do than what the individual is actually there for, and this happens time and time again, that you lose that opportunity, I'm never going to go back, and Matt's right.

It's usually that qualified -- that individual that understands and they have to have -- you talk about a specialized service on medicals is at a, you know, occupational doc in that.

Even in this, we have a lot of licensed psychologists and social workers out there that don't understand the first responder's world, and they have to understand that, and that doesn't take a lot, but there is -- there is a lot of work.

I know NFFF did a lot of work on trying to get a certification program for those clinicians, and we're

having a big shortage for clinicians right now.

Those that gravitate to EAP, you know, I don't know if they're the best clinicians in the world, and you're looking at the expense factor. Mental health is not cheap. And normally when they're in that problem and if they've had some other -- they don't have a lot of money. I mean, they've already done that route.

MR. TOBIA: I'll be a cynic for a minute. I apologize.

I wouldn't -- the fact that's in here is tremendously -- is a tremendous step forward, because it really raises the bar on -- it elevates the bar on ensuring that the services are available.

Getting emergency services personnel to take advantage of those services is a whole 'nother topic that you're not going to be able to -- I would not observe that there is a regulation that could drive that to occur. But making it available it a huge step forward.

MR. INGRAM: It's a great segue into our next section, which is training, and if we -- if we decided to do a training matrix or suggest training matrices,

we could add in this training as a line item in that.

So, we're in this level of training for the worker and maybe supervisory training.

So, that would get you one more step closer.

MR. TOBIA: If we're heading for training, could I offer a suggestion?

That is a huge rock. We are at the end of a very long, productive day, but I know that there's a fatigue factor, and I think, quite honestly, if you want to get the very best of us, as participants, that saving that for our next meeting might be the best thing to do, but I'll defer to the group for sure.

MR. INGRAM: Well, we've got -- it's quarter to 4:00. I'll let Lamont take over now.

(Laughter.)

MR. BYRD: I hear your recommendation.

MR. LEVINSON: I think however the group wants to handle it. I recognize it's 10 to 4:00, and honestly, I feel like we've got a lot of ground to go back over for the medical piece, and you know, that's a big chunk. I think the training is another really big chunk.

MR. INGRAM: What if we took a 10-minute break and then came back? And then I don't know if we have any public speakers or not. We have to allow for people from the public -- how many people from the public do we have besides Anne? I think Anne's the only one.

MR. LEVINSON: Were you interested in speaking?

MS. SOIZA: No.

MR. LEVINSON: I think that point of order is taken care of.

MR. INGRAM: Anne, did you have anything else you wanted to say? We'll just do that informally.

MR. LEVINSON: Let me add one more piece for the next meeting.

We had a discussion -- "we" being OSHA -- with OSHPA, which is the state plans associations -- so, it's all the state plans -- and there was a desire amongst that group to come and talk with this workgroup or the subcommittee.

In particular, I think -- and I don't want to get too far into representing what their perspective

is, but I think that they wanted to talk about, in particular, some of their concerns and/or experiences dealing particularly with small departments and volunteer departments, and I think they want to talk with you all and get your perspective.

So, we're going to add that to the agenda, as well, for the next meeting, and we'll bring in a couple of OSHPA folks to represent, you know, that perspective.

MS. DELANEY: Do you have a tentative date for the next meeting?

MR. LEVINSON: So, I think what we're looking at is something in February. We've been kind of doing every other month, and so, we've got to find some medical folks to come in and talk, representing a diversity of perspectives and experiences, and then, you know, the state plans, and that will take a good chunk of the meeting, but I think perhaps -- you know, we may also want to look at the risk management plan piece and the community risk assessment piece, because we have to circle back to that.

So, it may be that training -- if we can nail

all of those down at the next meeting, maybe even training gets put off and there's a whole meeting unto itself. How does that sound to folks?

MR. BYRD: Well, with that being said, are there any closing comments, closing remarks?

MR. DeVILBISS: Andy, if I could, when we were talking about, you know, the medical subject matter experts in there, and since we spent a lot of time, it's fallen out about the mental health part of it, maybe one of those could be a representative from that aspect, as well, within that group.

MR. LEVINSON: So, what I would say is, generally, with these types of committees, you know, where we think we want to bring people in is where you think it's necessary to have somebody to advise you so that you can make a recommendation. So, if there's a particular expertise -- being really candid, I didn't hear a lot of concerns about the draft regulatory text for the mental health, the way that it was written, and so, the question is, would bringing in an expert help you change your opinion, form a different opinion, or is this something that is close enough where the

committee is happy, whereas I think on the medical, there was more discussion about what's appropriate for the different groups.

So, that's, I think -- you know, it doesn't make sense to bring somebody in -- and is there a real question that that person is going to help this committee answer.

MR. FONTENOT: Andy, with that being said -- this is Kenn Fontenot -- since the medical thing will be discussed at the next meeting and the smaller departments will probably be largely impacted, I'd ask that we be able to bring in a representative from a small department, and we have somebody at the Fire Council that we would like to bring in.

MR. LEVINSON: Yeah, I think that we would want to get a diversity of perspectives. There's lots of different ways to skin this cat, and we'd like to hear, you know, different approaches, but again, the ultimate goal for bringing in experts is to help this workgroup get to the point where you can make a recommendation to NACOSH about what you think is appropriate, an appropriate approach for reg text for

medicals.

MR. INGRAM: I didn't have anything else. We have several action items, and I think everybody has their action items to go forward, and we have some statistical data that's going to be brought in, and then one of the action items that I didn't -- might not have specifically mentioned was that, if it's all right with the group, I'll have Steve Mason from EPA, who is also leading the LAPCs for Region VI, to discuss -- to work with the -- available, at least, to work with subcommittee three.

MR. MORRISON: When are you planning on meeting next?

MR. INGRAM: That's the next question.

MR. LEVINSON: I think Grady had a comment.

MR. DeVILBISS: Mr. Chairman, I had made a note while Pat and Matt were out of the room. We were talking about seven and eight there, and I just made a note. I think, Chris, you had brought up a point, maybe, that the assessment committee -- I just made a note there that we need to evaluate that.

I think we've worked through seven and eight

pretty well. I just want to make sure that there's something that's not an expectation of either committee that we've got going that we missed.

MR. LEVINSON: You're talking about questions seven and eight on health and fitness and the behavioral health and wellness.

MR. DeVILBISS: That's correct, Andy. I didn't know -- I thought maybe we were going to -- Chris had maybe suggested that the subgroup -- we can look at that --

MS. TRAHAN: The medical subgroup?

MS. DELANEY: Yeah.

MS. TRAHAN: Are we calling that workgroup four?

MR. INGRAM: I assume we will, yes.

MS. TRAHAN: Well, I had made the suggestion that they take on the behavioral health and wellness program that's in question eight, paragraph G-6 of the draft reg text, but I don't think that's necessary at this point, because I think the conclusion -- that's been pretty well concluded.

But I think I made the suggestion that the LEP

folks talk with workgroup three --

MR. INGRAM: That's correct.

MS. TRAHAN: -- as far as the community, and that's when Pat and Matt were out of the room.

So, I don't know if that's appropriate or not. That was thrown out at that point.

MR. INGRAM: Just wanted to suggest that we have an LEPT person work with you guys on the CERA information so that we can kind of tie that in for chemical reporting through the -- that's Region VI.

So, they have five states, Texas and the surrounding states, and he works with our service organization all the time, and he's actually probably going to help lead a national organization for LAPCs, which is lacking right now.

MR. MORRISON: Would he come in?

MR. INGRAM: Either way. He's available and he wants to help.

MR. MORRISON: January 6th?

MR. INGRAM: I'll get you his contact information and I'll step aside.

MR. MORRISON: Okay.

MR. TOBIA: Just a question, Andy.

When subject matter experts are asked to come in and give testimony before this group, how does that -- are they on their own dime?

MR. LEVINSON: Usually we will pay for somebody to come in, but it's not an unlimited pot of money.

MR. TOBIA: Understood.

MR. LEVINSON: So, you know, we want to make sure that we're getting people who reflect sufficient -- issues that are sufficiently big.

So, for example, you know, it may make sense to do a phone call between this LEP person and, you know, the community, whereas bringing in medical folks to talk to the whole committee, because that is a large topic, you know, may make more sense.

But ultimately, again, the real question is, does what we're doing get us to reg text that the committee can support broadly.

MS. SHORTALL: FACA, the Federal Advisory Committee Act, also allows all or any part of a meeting to be held telephonically. So, if there are persons

who would want to participate by phone, we certainly can do that, as well, a very cheap way to get our experts here.

MR. INGRAM: Two months from today would be February the 9th, if we wanted to meet on a Tuesday again, or we can pick another day.

MR. LEVINSON: Is it easier to -- Bill has been, I think, sending out emails?

MR. HAMILTON: If you guys all know of a date today, we'll live with it. I mean, we'll make it work. But otherwise, yes, I've been sending emails with two or three days asking for people's availability or preference.

MR. BYRD: I think if Bill would just send out some dates -- because I don't have a calendar I can work from today.

MR. INGRAM: Okay.

MR. HAMILTON: Will do.

MR. INGRAM: All right. Is Tuesday a good day for everybody, usually?

(Pause.)

MR. INGRAM: With all that useless

information, I want to say thank you to everybody. This has been a wonderful meeting, great input, very frank discussion. Thank you so much, and thanks for all the work that you have done, and thanks to the subcommittees that are going to be working in the future.

So, we'll thank you in advance for that.

MR. LEVINSON: Just a quick comment. You know, with this being our second meeting, I can see that, you know, as a group, we are also starting to kind of establish some comfort level with one another. So, I anticipate that this will continue to be a very productive group in the future.

MR. WARREN: I just wanted to say -- just reminded by Anne that the OSHPA state plan meeting is on February 9th.

MR. INGRAM: Not a good week.

MR. WARREN: Just for your note, Bill.

MR. INGRAM: I wanted to say thanks to Bill. He's really been a huge help getting all these documents together and coordinating our meetings.

MR. HAMILTON: It's a great team, good support system.

MR. INGRAM: Good job. And to Andy for your support. And for Sarah for not kicking me today too much. I've got a little bruise but not bad.

So, thank you all very much.

With that, do I hear a motion to adjourn?

(Moved and seconded.)

(Whereupon, at 4:00 p.m., the meeting was adjourned.)

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