COVID-19:
Interim After-Action Report

Purpose

During the COVID-19 health crisis, fire fighters and EMS personnel have fought to be recognized as essential frontline workers. Members of the International Association of Fire Fighters (IAFF) lack proper personal protective equipment (PPE) and other supplies, and access to priority testing. Our members continue to be left out of conversations on how to address the COVID-19 pandemic.

The Trump administration has and continues to ignore the gravity of the pandemic and refuses to publicly support a national response plan. This lack of action and initiative has significantly hampered IAFF members' ability to prepare and respond.

This paper is intended to document and serve as a reference of the challenges IAFF fire fighters and EMS personnel have faced and continue to face during this pandemic and the guidance, resources and support the IAFF developed as the coronavirus continued to spread throughout the United States and Canada. It also includes recommendations to ensure IAFF members are classified as essential healthcare workers.

Overview

On December 31, 2019, China notified the World Health Organization (WHO) of several cases of pneumonia in Wuhan, identified as a novel coronavirus (2019-nCoV or COVID-19) related to SARS, and reported the virus had been isolated on January 7, 2020.[1]

In the United States, the federal government was slow to begin its response. *The Washington Post* reported that President Trump and Congress had received several warnings and briefings from U.S. intelligence agencies that the virus posed a global threat.[2] Health and Human Services (HHS) Secretary Alex Azar presented findings from a Centers for Disease Control and Prevention (CDC) report to White House officials as early as January 3. However, the administration ignored the increasing threat and did little to nothing to prepare the nation. Even after U.S. diplomats were brought home from Wuhan – "a sign that the public health risk was significant," reported the *Post* – Trump's advisers struggled to convince him to take the virus seriously, according to multiple officials with knowledge of meetings among those advising the president.[3]

On January 17, the CDC began entry health screenings at San Francisco, New York (JFK), and Los Angeles (LAX) airports. The CDC activated its Emergency Operations Center establishing its Coronavirus Incident Management system on January 21.[4] The CDC confirmed the first case of coronavirus in the United States on January 21: a Washington state man in his 30s who had just returned from Wuhan, China.

That same day, the IAFF assembled an internal coronavirus response team to address the health concerns and challenges our members might face.

On January 30, the WHO declared COVID-19 a Public Health Emergency of International Concern (PHEIC) and warned that the virus was expected to spread internationally.[5] The next day, January 31, HHS Secretary Azar declared a public health emergency in the United States.[6] The declaration of a public health emergency by HHS made COVID-19 a top priority for the federal government, states, local health departments and the IAFF.

IAFF Response

As the pandemic became more widespread each day, the IAFF identified gaps between readily available information and the needs of our membership. With limited information, the IAFF followed guidance from various U.S. and international agencies, including the WHO and the CDC.

Because COVID-19 is a new coronavirus, guidance was not readily available or was flawed. This further hampered the IAFF's efforts to find scientific and medical expertise to ensure members followed appropriate protocols during the rapidly changing situation.

With new research continually reshaping the response to this virus, the IAFF could not rely with any certainty on the guidance provided by the CDC. In some cases, the IAFF was left to develop our own guidance based on information about the transmission of the virus, including dispatch protocols, quarantine and isolation, shortages of PPE and testing, as well as other protocols to protect members' safety. These issues became the IAFF's top priorities as we consulted with federal agencies, Johns Hopkins University physicians and other subject matter experts. Many of these issues remain top priorities.

Early on, the IAFF developed coronavirus resources for members, including guidelines for responding to patients possibly infected with COVID-19. In March, as cases of COVID-19 among fire fighters and EMS personnel rose, the IAFF developed a tracker survey for affiliates to document COVID-19 exposures – and deaths – within their respective fire departments. The information collected is used to make timely and informed decisions regarding PPE needs, funding, guidance documents and legislative efforts at the state and federal levels.

As of September 9, the tracker survey shows that more than 26,000 members exposed, 10,709 members quarantined, 5,219 members isolated, 122 members hospitalized, and 16 line-of-duty deaths from COVID-19.

As the crisis evolved, it became clear that the role of IAFF members in the healthcare system was not recognized. Because fire fighters and EMS personnel are not classified as priority frontline workers, members had difficulty obtaining PPE and other supplies. The prehospital care that fire fighters and EMS provide to their communities was either not understood or an afterthought in the initial distribution of supplies and resources to fight COVID-19.

Neglecting Pre-Hospital Care

The CDC's initial guidance documents, which focused on healthcare settings (e.g., hospitals, skilled nursing facilities, physicians' offices), as well as Intensive Care Units (ICUs) and the need for ventilators, failed to recognize that pre-hospital response is a major function for fire fighters and EMS personnel. This left the IAFF in a constant state of catch up.

The CDC's focus on healthcare settings and delay in issuing guidance for fire fighters and EMS personnel was shortsighted and created a major systemic operational failure in providing the most up-to-date information respective to emergency response. The CDC has since created guidance specific to fire fighters and EMS providers, although it has consistently fallen short in providing guidance for adequate protection.

One of the initial problems was that CDC dispatch guidance recommended questioning patients under investigation only about travel outside the United States – not about symptoms associated with the virus. Additionally, this line of questioning gave responding fire fighters and EMS personnel inaccurate or incomplete patient information[7] and ignored the fact that COVID-19 could be – and was – spread through community transmission. Call takers were not asking relevant questions relating to the patient about fever, coughing or shortness of breath; therefore, IAFF members dispatched to respond were not alerted about possible COVID-19 patients. As a result, IAFF members were sent on calls thought not to be COVID-19 without donning the proper PPE. Consequentially, numerous preventable exposures occurred.

The IAFF quickly worked to change dispatch protocols so that fire fighters and EMS personnel were notified that emergency call centers had modified caller queries to rely less on questions regarding travel abroad and more on signs and symptoms, especially shortness of breath. This allowed responding fire and EMS personnel to don the most appropriate PPE.

While the IAFF worked to change these CDC dispatch protocols, we also provided our own guidance documents highlighting the need for proper PPE on all calls. Official dispatch protocols have now been changed, along with call response protocols, and proper PPE is required for all EMS calls.

From the beginning of this pandemic, IAFF members have experienced new occupational exposures, long hours, staff shortages, dramatic lifestyle changes and new stressors surrounding unknowns about COVID-19. Despite these challenges and concerns, our professional fire fighters and emergency medical personnel risked exposure to COVID-19 and showed up every day to perform their job to ensure their communities remained safe and that those who needed medical attention received it.

Quarantine and Isolation

When IAFF members from Kirkland Local 2545, Redmond Local 2829 and Woodinville Local 2950 in Washington state required quarantine after their exposure at the Life Care nursing home,[8] guidance on quarantine and isolation was minimal at best, and testing was essentially unavailable to our members who remained on the frontlines every day. Worse, our federal government was unprepared to provide that guidance. The IAFF worked with our affiliate leadership in Washington state to quickly develop informed guidelines and resources to help keep our members safe from this new virus.[9]

With fire fighters and EMS personnel in quarantine, many IAFF members worked overtime to cover shifts. This also increased the risk of exposure to COVID-19 patients and at times reduced staffing to below the national industry standards for safe and effective response.[10] This created a dynamic in which local departments could have more sidelined fire fighters and EMS personnel in quarantine than an operational workforce to protect their communities.

The CDC's guidance for healthcare workers, which defined high-, medium- and low-risk exposure as determining factors for quarantine or isolation,[11] did not account for the uncontrolled and high-risk environments IAFF members work in every day. Therefore, the IAFF developed its own guidance for exposure risk that included high or low risk.[12] A high-risk exposure requires quarantine for 14 days while practicing social distancing and monitoring for signs and symptoms of COVID-19; a low-risk exposure allows return to work while monitoring for symptoms.

The IAFF also needed to make sure fire fighters and EMS personnel had a place to stay or self-quarantine close to their work location and away from their homes and families to protect their loved ones. The IAFF worked with several hotel chains – including Hyatt, Marriott, and IHG Hotels and Resorts – to offer reduced rates for members to quarantine or isolate.[13] In addition, Red Roof Inn and Furnished Quarters in New York City offered discounted rates to our members.

Meanwhile, Hilton and American Express were partnering to donate up to 1 million rooms to frontline medical professionals.[14] The program provided rooms to 20 organizations but excluded the IAFF – even though IAFF members are frontline medical professionals. Over several weeks, the IAFF worked to ensure members were included in this program. Additionally, over the course of the program, nearly 2 million room nights were made available for all participating organizations. Hilton continues to provide rooms at a discounted rate for IAFF members.

Staffing Concerns

Because of the COVID-19 pandemic, the Candidate Physical Ability Test (CPAT), one of several components that make up the hiring process to become an entry-level fire fighter, was forced to shut down to keep both applicants and CPAT proctors safe, leaving many prospective fire fighters unable to enter the workforce. This created a staffing shortage across the United States. To ensure a regular flow of new hires continued, the IAFF worked with medical professionals to issue guidance on how to safely reopen applicant test facilities to administer the CPAT.

Pearson Vue© Testing Centers (PVTSCs) – state-owned testing facilities within colleges and universities – were also shut down because of COVID-19. The PVTSCs administer the emergency medical technician (EMT) and paramedic certification exams.

However, because of the shutdown, the National Registry of Emergency Medical Technicians (NREMT) reported that 12,000 students were unable to complete their certifications exams.[15] This further delayed the entry of EMTs and paramedics into the workforce, resulting in a shortage of emergency medical service providers to respond to the pandemic. The IAFF worked with the NREMT to contact the National Governors Association to request reopening state-owned PVTSCs. This collaboration resulted in PVTSCs resuming testing on a limited basis, and by April 20, 2020, students were able to begin testing and enter the workforce.

Personal Protective Equipment and Supplies

PPE are critical to minimizing high-risk exposures, yet shortages remain far too common. The IAFF guidance for proper PPE for responding to COVID-19 includes a minimum of a N95 respirator, gloves, impervious gown and goggles or full face-shield.

However, the immediate shortage of N95 respirators for fire fighters and EMS personnel and healthcare workers forced the CDC to issue insufficient guidance allowing surgical masks to be worn as a substitute for an N95 respirator. Specifically, the CDC guidance recommended that "facemasks are an acceptable alternative when the supply chain of respirators cannot meet the demand."[16]

On March 11, IAFF General President Harold Schaitberger wrote to HHS Secretary Alex Azar condemning the CDC guidance that facemasks are an "acceptable alternative" to N95 respirators. The letter stated that fire fighters continually work in uncontrolled and unpredictable environments in contrast to the more controlled settings in healthcare facilities; therefore, the recommendations for one type of work environment may not be appropriate for another. The IAFF's position is and will remain that the N95 or higher respirators afford the best protection for our workforce for responding to and caring for suspected and confirmed COVID-19 patients. On April 2, the CDC updated its guidance to recommend a minimum of an N95 respirator.[17]

From the onset of the COVID-19 pandemic in the United States, PPE supplies have been severely lacking. Meanwhile, healthcare workers and other first responders became critically ill – with some dying from COVID-19.[18] This added undue mental stress on our members who protect and serve the public but were provided with little to no federal guidance or operational support.

The CDC guidance on PPE for healthcare workers once again ignored fire and EMS personnel who provide pre-hospital care. Without federal support, IAFF members were unable to acquire the proper PPE to protect themselves from COVID-19.

On March 23, the IAFF wrote to HHS Secretary Azar requesting that our members receive priority on the distribution of PPE. Simultaneously, the IAFF also lobbied Congress to make HHS issue a mandate, but it was and remains reluctant.

Fire fighters and EMS personnel learned during a national presidential task force briefing on April 27 that they were given a "tier one/level five" priority for receiving or purchasing PPE, putting IAFF members fifth in line (after hospital workers and other essential personnel) for receiving PPE and displaying a blatant disregard for fire fighters' and EMS personnel's role as the first point of contact with a COVID-19 positive patient.

This failure of priority recognition forces IAFF members to dangerously reuse PPE, which is designed for single use and disposable so as not to expose fire fighters and EMS personnel or cross-contaminate patients. The IAFF continues to maintain that the very nature of pre-hospital response requires that fire and EMS personnel are "tier one-level one," along with other critical healthcare workers.

As the federal government prepared to release inventory from the national strategic stockpile, it realized the stockpile had not been properly maintained since it was created and stocked in 2003. Since 2003, the national stockpile had been managed by the CDC, but in 2018, the Trump administration moved oversight of the program to the Assistant Secretary for Preparedness and Response. The move created a logistical operation disconnected from the public health officials charged with managing the response. Public health officials and lawmakers worried that the decoupling of supplies from the medical professional side of the response would "disrupt a complex process that relies on long-standing relationships between the federal program and the state and local agencies" and "politicize decision-making about products bought for the stockpile."[19]

It turns out they were right, and the timing could not have been worse.

With the national stockpile depleted, on February 5, HHS Secretary Azar asked the Office of Management and Budget (OMB) for $2 billion for PPE and supplies but was denied. The request was cut to $500 million when the White House sent Congress a supplemental budget request on February 24.[20]

As distribution began, it was quickly determined that many of the supplies, including N95 respirators, were well past their expiration date and were being used without knowing if they provided full protection. CDC analysis of these expired respirators concluded that "consideration can be given to use the N95s … past their manufacturer-designated shelf life when responding to COVID-19."[21]

As it evaluated the expired stockpiles, the CDC acknowledged that "the respirators exceeding their manufacturer-designated shelf life are only being released due to the potential urgent demand caused by the COVID-19 public health emergency." However, these masks were not fully evaluated because they were not tested for fluid resistance.[22] As IAFF members accessed these expired masks, many were damaged and unusable. PPE shortages throughout this national response has put IAFF members unnecessarily in high-risk exposure scenarios without proper protection.

Without a reliable supply chain to fill an already depleted stockpile, a vast number of counterfeit masks began to flood the U.S. supply chain. The reliance on China and other foreign countries to manufacture PPE left IAFF members vulnerable to increasing counterfeit supplies. Still, the CDC began to support N95 and KN95 respirators from other countries, including China.[23]

The IAFF, working with industry experts – and in the absence of guidance from the federal government – developed and issued guidance on identifying counterfeit PPE, as IAFF members reported that their departments had received counterfeit respirators, mostly imported from China.[24] Once again, the CDC later acknowledged the problem and provided information on counterfeit respirators and how to identify them.[25]

Testing

Early on, without enough tests readily available, it was incredibly difficult for fire fighters and EMS personnel to get tested for COVID-19. The most reliable tests – according to industry experts – is the RT-PCR swab test, or nasal swab COVID-19 test. IAFF members faced several issues in regards to testing: (1) the inability to secure nasal tests; (2) results, once testing became available, sometimes took more than seven days; and (3) fire departments were forced to either quarantine members who may not be positive or allow asymptomatic fire fighters to work.

These complications compromised the safety of IAFF members and their families, as well. Even as test kits became more readily available, fire fighters and EMS personnel still were not considered a high priority.

Because fire fighters and EMS personnel are at a high risk of exposure to COVID-19, they must be given priority for both rapid PCR testing and antibody testing. However, there is no federal testing strategy, and priority status and availability for testing varies state to state, making it difficult to advise members on how to obtain tests in their state. Some cities, such as Washington, DC, have made free testing available. In New York[26] and Georgia,[27] priority testing is provided for emergency responders. Unfortunately, this is not the standard in all states and cities.

On April 16, the IAFF again wrote Secretary Azar requesting that our members receive priority testing. The IAFF also lobbied Congress, but it was and remains reluctant to issue a mandate from the administration.

In the absence of reliable testing, questions remain regarding the types of tests to be used, the appropriate time to administer the test and how to interpret test results that may not have the required sensitivity. The IAFF has developed guidance on the two main COVID-19 testing methods. Diagnostic tests are more capable of informing whether a person has active virus, while antibody (serologic) tests inform whether someone has been exposed to or has some level of immunity to the virus. Unfortunately, more research is necessary to determine the accuracy of serologic test results for COVID-19 and how to best use this technology to slow or stop the spread of this disease.

The Food and Drug Administration (FDA) issued emergency use authorizations (EUAs) to several manufacturers in order to rapidly deploy new COVID-19 tests.[28] Tests that receive an EUA can be used under emergency situations but are not FDA-approved. In the rush to go to market, the FDA did not evaluate the reliability of a majority of tests granted EUAs and did not clearly identify which of the two tests – diagnostic or serologic – should be used to determine if someone is COVID-19 positive or already had the virus.

Few of these tests were reliable, causing confusion for fire fighters and EMS personnel and potentially providing ineffective tests and inaccurate results. Working with doctors from Johns Hopkins University, the IAFF quickly developed and distributed detailed guidance, along with recommendations on the use of available tests.

Realizing the inaccuracy and lack of reliability of serologic (antibodies) tests, the FDA updated its policy and removed EUAs from several manufacturers, creating a smaller pool of available tests.[29]

The IAFF supports the current recommendations from the FDA that results from serologic testing alone should not be used to diagnose or exclude COVID-19 infection or to inform infection status. The IAFF further advises against the use of serologic testing alone as the basis for return-to-work decisions. Rather, such determinations should also include molecular testing and an evaluation by a healthcare provider.

Vaccines

As of the writing of this report, more than 165 companies and pharmaceutical manufacturers are working to identify a vaccine that will "put a stop to this pandemic."[30] As of mid-August, eight vaccines are in phase three trials and two were approved for early or limited use.[31]

The IAFF continues to monitor vaccine development and deployment. Because the vaccine will be in high demand and initially in short supply, the IAFF recommends establishing a priority list for distribution, with fire fighters and EMS personnel at the highest priority. Pre-hospital response is the first line of defense against this virus and, like PPE and testing, fire fighters and EMS personnel need to be top priority to protect the public.

Additionally, once a vaccine is widely available and distributed, fire fighters and EMS personnel may be required to assist in a national vaccination program. IAFF affiliates and their fire departments have been part of national vaccination programs in the past; therefore, fire fighters and EMS personnel need to be prioritized for the vaccine.

On October 2, 2020, the National Academies of Sciences, Engineering, and Medicine (NASEM) released the final report on the Framework for Equitable Allocation of a COVID-19 Vaccine for adoption by HHS, state, tribal, local and territorial authorities. The IAFF provided public comment as an engaged stakeholder and helped to secure all first responders into Phase 1a, alongside high-risk health workers. All states have been asked to develop a distribution plan following this document.

Behavioral Health

COVID-19 has impacted the lives of IAFF members on the job, at the fire station and at home with their families. Unfortunately, no behavioral health guidance has been issued from any federal agencies. The IAFF understood from the very beginning that the mental and emotional toll for our members and their families would be severe, and developed and made readily available behavioral health guidance for members struggling with the day-to-day stress and concerns for their own safety and their families' safety. This behavioral health guidance includes:

- Coping With Grief During COVID-19: Saying Goodbye to Loved Ones
- Helping Your Family Cope With COVID-19
- What to Expect in Quarantine

Throughout this pandemic, the IAFF Center of Excellence for Behavioral Health Treatment and Recovery has remained open with safety precautions in place to provide the highest level of behavioral healthcare to IAFF members.[32] The IAFF Center of Excellence is a one-of-a-kind treatment facility for IAFF members who are struggling with addiction, post-traumatic stress disorder (PTSD) and

other related behavioral health challenges. Since the COVID-19 pandemic began, the Center of Excellence has acted swiftly to develop and implement a comprehensive patient safety infection control plan. By adopting admission restrictions, new admission screening and protocols and requiring all patients and staff to always wear PPE, the Center continues to provide high-quality care.

Most recently, the Center has also transitioned to offer telemental health services for patients in Maryland, Virginia and the District of Columbia receiving non-intensive outpatient care.[33] Additionally, in response to the COVID-19 global pandemic, the IAFF has provided new services and resources to address the unique stressors IAFF members are facing, launching online recovery meetings, telemental health services and a new series of behavioral health information guides on a variety of COVID-19 topics.

Filling the Void in the National and State Response

The IAFF continues to work to pass COVID-related legislation and regulatory policies amidst a national response at both the federal and state level.

State responses to this pandemic have varied wildly as state leaders' perspectives on the seriousness of the pandemic determines how states are governed. State-level assistance and support for fire fighters and EMS personnel differs vastly from state to state. Cautious state leaders have been quick to impose stay-at-home orders, mandate masks and divert funds to provide needed supplies and services. Other state leaders have been late to impose restrictions, if any at all, and lack funds or the willingness to restructure funds to provide aid.

Unfortunately, in many cases, lack of presumption laws specifically for COVID-19 created a void in benefits for fire fighters or EMS personnel who contract the virus. Workers' compensation coverage is a state issue, thus, placing the burden on state and local IAFF affiliates to either amend existing laws to include COVID-19 or pursue executive or legislative action.

Additionally, occupational exposure to COVID-19 has required many fire fighters and EMS personnel to quarantine. Because of discrepancies in state law, some quarantined members have had to use their own personal sick leave or use administrative leave for the period of isolation. The IAFF is tracking states offering paid administrative leave and workers' compensation coverage for fire fighters and EMS personnel.

Meanwhile, in the middle of this pandemic response, the IAFF successfully worked to update the Ryan White Act and the Public Safety Officers Benefit (PSOB) program to include COVID-19. Simultaneously, the IAFF is working with affiliates at the state and local level to ensure COVID-19 related illnesses, injuries and disabilities are considered job-related and covered under workers' compensation.

Ryan White Act

IAFF affiliates reported in March that members who may have had contact with an individual who tested positive for COVID-19 were not notified by hospitals of their potential exposure. Many hospitals that refused notification of the potential exposure did so claiming COVID-19 was not listed under the Ryan White Act. This posed a serious problem for fire fighters and EMS personnel responding to calls with a high risk of exposure. While some hospitals were communicative, most claimed they could not share positive test results because of the lack of coverage under the Ryan White Act, citing patient confidentiality.

Passed in 1994, the Ryan White Act was designed to provide resources for HIV and AIDS patients. One very important component of the bill is an inclusion that requires post-exposure notification if an emergency response employee (including fire fighters and EMS personnel) had contact or exposure to an individual carrying a bloodborne or airborne transmissible disease. Hospitals are required to notify emergency responders no later than 48 hours after test results are conducted of a potential exposure. This protects emergency responders who might not otherwise have known they were exposed to an illness.

Diseases requiring notification under the Ryan White Act include HIV, Hepatitis B, Tuberculosis, meningitis, hemorrhagic fevers, plague and rabies. The list of notifiable diseases is occasionally updated by the CDC via regulation and was last updated in 2011. The CDC stipulates that, in the event a new infectious disease fits the criteria for inclusion in the list of potentially life-threatening infectious diseases required by the Ryan White HIV/AIDS Treatment Extension Act of 2009, it will amend the list and add the disease.

The emergence of COVID-19 and the failure of hospitals to notify emergency responders of their exposure prompted the IAFF to petition the National Institutes for Occupational Health and Safety (NIOSH) in early March to update the list of diseases requiring notification under the Ryan White Act to include COVID-19. Working closely with the IAFF, NIOSH quickly updated the regulations on March 26.[34] Hospitals are now mandated to notify emergency response employees of any exposure to a possible COVID-19 patient. Fire fighters and EMS personnel who are exposed to individuals who test positive for the virus will now be notified. .

Public Safety Officer Benefit

The Public Safety Officer Benefit (PSOB) program provides benefits to the families of fire fighters who die or are permanently and totally disabled in the line of duty. Absent presumptive language, fire fighters and EMS personnel would be required to prove they contracted the virus on the job to receive federal benefits, a nearly impossible task. Fire fighters and emergency medical personnel run multiple medical calls a day and have no way of knowing if any individual interaction resulted in transmission. As of August 2020, 15 IAFF members have died from COVID-19 and tens of thousands of members have been exposed. These numbers continue to rise.

The IAFF worked with Congress to pass legislation (Safeguarding America's First Responders [SAFR] Act of 2020) with strong bipartisan support to include a COVID-19 presumption for PSOB. By passing the SAFR Act, Congress recognized the danger inherent in the jobs of public safety officers on the frontlines of the current pandemic, and rightly affords the families of the fallen the benefits they deserve. This legislation has been signed into law and expires on December 31, 2021.[35] The PSOB benefit in FY 2020 is $365,670.

Workers' Compensation

Workers' compensation benefits paid to workers who experience a job-related illness, injury, disability or death vary from state to state. Adding COVID-19 as a compensable benefit requires changing the law or issuing an executive order.

The IAFF is assisting numerous affiliates in these efforts, such as drafting model language for state legislatures.

Also, in April, the IAFF wrote to the National Governors Association advocating for executive orders granting fire fighters and EMS personnel workers' compensation coverage for COVID-19. To date, 10 states (AK, CA, IL, MN, MO, NJ, UT, VT, WI and WY) have successfully enacted legislation and six states (AR, CT, KY, MI, NH and ND) have secured an executive order establishing presumptive workers' compensation benefits or disability retirement benefits for fire fighters or emergency medical personnel who contract COVID-19.

Sick Leave

Under the Working Families First law, employees are granted emergency FMLA leave to care for children if the child's school or daycare is closed due to COVID-19 and an additional two weeks of COVID-related sick leave. However, the law includes an employer-only exemption for essential workers, such as fire fighters and EMS personnel. Nevertheless, some employers provided the extra sick leave, including in Salt Lake City, Utah, where the mayor issued an executive order providing emergency responders with sick leave.[36] On the state level, the New Jersey state legislature passed a bill providing paid COVID-19 sick leave to first responders.[37]

As of the writing of this paper, only two states (New Jersey and New York) and two cities (Salt Lake City, Utah and Kansas City, Missouri) provide paid COVID-19 sick leave to fire fighters and EMS personnel.

Assistance to Firefighters Supplemental (AFG-S) Grants

As part of efforts to address the PPE supply chain issue, Congress passed the Assistance to Firefighters COVID-19 Supplemental (AFG-S) grant program, providing $100 million for fire departments to purchase PPE and related supplies and equipment to prepare for and respond to COVID-19. The additional $100 million was appropriated in part because PPE is in high demand and short supply, making the cost for these items higher, further adding to fire department budget shortfalls.[38]

As of the writing of this report, AFG-S grant money is systematically and slowly being released by the Federal Emergency Management Agency (FEMA) to fire departments. With one-third of the grant money already awarded, new reports continue to expose the failure of the federal government in their preparedness for this pandemic. Counterfeit supplies continue to infiltrate the supply chains and departments are unable to secure the supplies they need. The IAFF remains focused on lack of supply, lack of priority and competition for PPE on the commercial market as businesses and schools move to open.

Relief Packages

The IAFF has, since mid-February, engaged lawmakers in a conversation regarding the needs of fire fighters and emergency medical personnel due to the COVID-19 pandemic. Despite aggressive lobbying, the Families First Coronavirus Response Act – the first relief package passed by Congress – did not adequately address the needs of fire fighters and EMS personnel. The $8.3 billion for vaccines, disaster loans and a host of other items was directed primarily to healthcare personnel and funneled through HHS. Although Congress's intention was for the whole of the healthcare community to benefit from these funds, bias within HHS and a failure of the federal government to properly recognize fire fighters and EMS personnel as part of the healthcare infrastructure resulted in the majority of this money going to traditional healthcare providers, such as hospitals and nursing homes, and very little reaching fire departments or fire and EMS personnel.

A second relief package focused more on small business and economic relief and contained few resources or benefits for workers. Fire fighters and EMS personnel fared better in the third relief package. The CARES Act included $100 million in Assistance to Firefighters Supplemental (AFG-S) grants; $45 billion for the Disaster Relief Fund to reimburse fire and EMS departments for expenses related to the virus; $100 billion to reimburse healthcare providers, including EMS, for healthcare expenses or lost revenue; $41 million for the National Forest System and Wildland Fire Management for PPE and baseline health testing for first responders; and $150 billion in funding for state and local governments to address COVID-19 expenses, including PPE and payroll expenses for personnel, and funds to accommodate quarantine and isolation measures.

As of the writing of this document, a fourth COVID-19 package with potentially significant resources and benefits for fire fighters and EMS personnel is in negotiations in Congress.

The IAFF continues to publicly call for increases in priority status in the delivery of PPE, testing and vaccines, as well as financial assistance for fire departments and state and local municipalities.

FEMA Plan Leaves Out Fire and EMS

Under the Stafford Act, federal agencies follow FEMA's National Emergency Operations Framework to coordinate with state and local governments and private and nonprofit organizations. The plan recognizes and calls for 15 distinct operational emergency support functions (ESF). Federal agencies are assigned a defined set of functions and corresponding oversight. Using the National Incident Management System as its guide, this plan is designed to provide a coordinated response.

However, during this pandemic, the plan falls short in delivering a coordinated and cooperative process that addresses the urgent needs of the fire and EMS service by providing available resources. Which federal agency has oversight responsibility is where the national plan breaks down.

As an example, EMS is represented under the Department of Transportation (DOT), the National Highway Traffic Safety Administration (NHTSA) and the Office of EMS (OEMS) because of fatalities caused by motor vehicle accidents.

During this response, medical oversight and the stockpile falls under the Department of Health and Human Services (HHS), which oversees hospitals but lacks any structured oversight of prehospital care. This does not bode well for fire fighters and EMS personnel who are first on scene for all prehospital emergencies.

The federal government managing the response under HHS does not recognize EMS in this prehospital capacity. The OEMS is overshadowed by the other federal partners responsible for emergency response, as EMS does not fall under any of the emergency support functions (ESF)39 in the National Response Framework document.

The fire service designation within the plan is "ESF-4 Fire Fighting." Under the plan, ESF-4 is defined as follows: "Firefighting provides federal support for the detection and suppression of wildland, rural and urban fires resulting from, or occurring coincidentally with, an all-hazard incident requiring a coordinated national response for assistance." FEMA recognizes, rather briefly, "Many firefighting agencies provide additional functions, such as emergency medical services, technical rescue and hazardous materials response." This pithy mention in the plan fails to recognize the detailed responsibilities of today's fire service and further assigns major responsibilities of the fire service to other ESFs.

Affiliates understand that in a multi-agency response, the Incident Management System calls for a unified command to be operational. The examples above clearly show that under the FEMA response framework fire and EMS are not included in the national unified command setting. This is likely the key contributing factor to the frustrations fire and EMS have experienced during the coronavirus pandemic response.

Closing

Federal guidance does not address fire fighters and EMS personnel as priority pre-hospital workers. To this day, federal agencies do not recognize the multifaceted role of today's fire service. This lack of recognition came to light during this national pandemic and has left IAFF members – fire fighters and EMS personnel – without necessary equipment and tailored guidance. Issues including quarantine, isolation, priority testing, PPE and vaccination delivery must be addressed in the short term. Longer term, federal agencies have an obligation and a responsibility to fully understand, plan for and include the multifaceted role of the fire service today.

Review of IAFF Response

- Following IAFF insistence, the CDC created COVID-19 guidance specific to fire fighters and EMS personnel.
- The IAFF was the driving force in changing CDC dispatch protocols, along with call response protocols, to require PPE for all persons under investigation (PUI) for COVID-19.
- The IAFF provided guidance to its affiliates (that the CDC later adopted) to require a minimum of an N95 respirator and provide more pre-hospital direction.
- The IAFF developed partnerships with hotel chains to ensure fire fighters and emergency medical personnel have a place to isolate or self-quarantine close to their work location and away from their homes and families.
- The IAFF worked with the National Registry of Emergency Medical Technicians (NREMT) and the National Governors Association to request reopening state-owned Pearson Vue© Testing Centers (PVTSCs) to allow more than 12,000 students to take the emergency medical technician (EMT) and paramedic certification exams. This initiative created more professionally trained EMTs and paramedics to operate in the field.
- The IAFF implemented online recovery meetings and a new series of behavioral health information guides on a variety of COVID-19 topics.
- The IAFF Center of Excellence for Behavioral Health Treatment and Recovery remained open for behavioral health and substance abuse recovery.
- The IAFF publicly influenced the national presidential task force prioritization working group to reorganize PPE priorities, moving IAFF members to "tier one-level three" from "tier one-level five."
- The IAFF worked with federal agencies to include COVID-19 in the list of diseases covered in the Ryan White Act.
- In the middle of this response, the IAFF worked with Congress to provide federal resources, including $100 million in Assistance to Firefighters-Supplemental (AFG-S) grant funding for PPE.
- The IAFF successfully amended the Public Safety Officer Benefit (PSOB), which provides benefits to the families of fire fighters and EMS personnel who die or are permanently and totally disabled in the line of duty, to include COVID-19.
- The IAFF worked with affiliates to ensure COVID-19 protections under workers' compensation for occupational exposures.

Recommendations Summary

- Federal agencies must fully understand, plan for and include the multifaceted role of the fire service. Any national or regional FEMA response plan included in the emergency operations framework must recognize the roles and responsibilities of the fire service.
- All FEMA response plans must designate and provide direct operational access to the agencies with jurisdiction over the individual role or responsibility provided by today's fire service.
- The IAFF recognizes the need for a national conversation, including a debrief to address the issues in this report.
- The IAFF requests representation on the Emergency Support Function Leadership Group (ESFLG) to represent fire fighters and fire-based EMS personnel.
- Fire fighters must be provided the highest-level priority for PPE and supplies, testing and vaccination.
- Absent prioritization, the federal government must ensure an adequate supply chain that provides PPE, supplies, testing and vaccinations at such levels that allow fire fighters and EMS personnel to protect themselves and the public.
- The IAFF advises against the use of serologic testing alone to make return-to-work decisions. Rather, these decisions should also include diagnostic testing and symptom surveillance, including an evaluation by a healthcare provider.
- State and local governments should be funded to provide adequate staffing, equipment, training, PPE, medical surveillance, testing, vaccines and behavioral health services.

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