NEW YORK STATE ASSEMBLY

PUBLIC HEARING

ASSEMBLY STANDING COMMITTEE
ON HEALTH

ASSEMBLY STANDING COMMITTEE
ON LABOR

ASSEMBLY STANDING COMMITTEE
ON EDUCATION

ASSEMBLY STANDING COMMITTEE
ON HIGHER EDUCATION

ASSEMBLY SUBCOMMITTEE ON
WORKPLACE SAFETY

Assembly Hearing Room
250 Broadway, 19th floor
New York, New York

Tuesday, October 13, 2009
10:20 a.m.

A P P E A R A N C E S:

RICHARD N. GOTTFRIED, Chair,
Committee on Health

DEBORAH J. GLICK, Chair,
Committee on Higher Education

RORY I. LANCMAN, Chair, Subcommittee
On Workplace Safety

CATHERINE T. NOLAN, Chair,
Committee on Education

LIST OF SPEAKERS

LIST OF SPEAKERS (Cont'd)

LIST OF SPEAKERS (Cont'd)

LIST OF SPEAKERS (Cont'd)

LIST OF SPEAKERS (Cont'd)

NYSA/10-13-09 H1N1 Influenza

CHAIRMAN GOTTFRIED: Good morning. Before we call up our first witness, just some introductory notes.

I'm Richard Gottfried. I chair the Committee on Health. Joining us today is Assembly Member Deborah Glick, Chair of the Committee on Higher Education; Assembly Member Cathy Nolan, Chair of the Committee on Education; Assembly Member Rory Lancman, Chair of the Subcommittee on Workplace Safety; and Susan John, Chair of the Labor Committee is not able to join us today, but will be getting copies of all the testimony and the transcript.

A few procedural notes. One, a reminder for those who have testified before the Health Committee, and for those of you who have not. At Health Committee hearings all testimony is under oath. The process is very simple. When you come up, take your seat. Turn to the stenographer. He will very quickly ask you to swear or affirm that you're going to tell the truth. And if you give the right answer, you get to testify.

You don't have to stand up or bring your own bible or anything like that.

We will, at about 1:00, take a 10-minute break for what we in the health world call ambulation and toileting. A little Health Committee joke there. As you can tell from the witness list, those of you who have looked at it, we have over 60 individuals lined up to testify which ought to keep us going to well past 10:00 tonight, if everyone testifies, and certainly if everyone takes a full 10 minutes.

I plan to stay here till the last person finishes testifying. And certainly the last few people who testify will obviously do the same. Anything you can do to alleviate the strain on your fellow

testifiers by brevity would certainly be encouraged.

If you do testify, feel free to say, by the way, I agree with what so and so just said. Also, I don't know if they're in the back of the room yet, but if not, we will shortly be bringing down a sheet of

paper headed "Alternatives to Testifying," and we invite you to put down your name, address, and e-mail and either check off that you're going to e-mail your testimony to us, or feel free to jot down -- we have a space to say, if I were testifying, I would agree with the following and put in a couple of names.

And we have a larger space if you'd like to write in a quick summary of what you would have said. We will include all of that material in the record of the hearing. What usually happens at hearings like this is that the witnesses who testify earlier in the day tend to get a lot of questions asked of them, and that's sometimes in part because they tend to be government agency witnesses, or, you know, it's early in the day, so we try to get more

information. And then, as it gets later in the day, we find that we've gotten a lot of answers to a lot of the questions we would have asked. So if, when you testify, nobody asks you a question, don't feel bad. Think

of it as a privilege.

I'm not going to make much of an opening statement except to say that each season, influenza is, I believe, a serious and definitely reducible hazard to public health. This year we have the addition of an extra strain on top of the three seasonal strains that we have, namely the H1N1 influenza, which, as far as I can tell, is not special in terms of its severity, but does seem to be a lot more contagious, so the concerns are considerably heightened.

So we decided to convene this hearing of the various committees to review what is being done, what various government agencies are doing and recommending, what non-governmental entities are doing.

It's obviously from the witness list that there are a lot of people here concerned about the H1N1 vaccine as well.

Cathy, do you want to add anything? No. Deborah?

ASSEMBLYWOMAN NOLAN: Looking forward to hearing everyone.

ASSEMBLYWOMAN GLICK: As chair of Higher Ed, we're interested in hearing what is happening on university campuses because of the concentration of young adults who seem to be more at risk than people my age, so that is the concern of the committee.

Thank you.

CHAIRMAN GOTTFRIED: Rory.

ASSEMBLYMAN LANCMAN: Good morning. As chair of the Subcommittee on Workplace Safety, I have a particular interest in how H1N1 affects the workplace.

As many of you know, the subcommittee issued a report last month, a preliminary report in anticipation of this hearing. I look forward to hearing from government agencies from employee organizations and from the general public, particularly focused on the issue of H1N1 in the workplace.

Most of the attention to this point has been on H1N1 in the schools or H1N1 in universities. I'm interested in issues such as the mandatory vaccination

issue for healthcare workers, a dispute between the Department of Health and the CDC on the issue of the appropriate use of respirators and, in general, what kind of planning employers, both government, public employers, and private employers are doing to prevent the spread of H1N1 in the workplace.

So I appreciate that we're having this hearing and I look forward to the testimony of all 60 of you.

Thank you.

CHAIRMAN GOTTFRIED: Okay. With that, we will call up our first witness, Dr. Guthrie Birkhead, Deputy Commissioner of the Department of Health.

(The witness was sworn.)

DR. BIRKHEAD: Good morning. Assembly Members Lancman, Gottfried, Glick and Nolan, thank you very much for this opportunity to testify today and to present the New York State Department of Health's response to the 2009 H1N1 Influenza pandemic.

NYSA/10-13-09 H1N1 Influenza

My name is Dr. Guthrie Birkhead, I'm the Deputy Commissioner for Public Health at the State Health Department.

Last April, New York Governor David Paterson directed the State Health Department to activate its Emergency Health Preparedness Plan in response to cases of H1N1 in New York State.

This plan was developed over a number of years of pandemic planning and involves the collaboration of programs across the health department, other state government agencies, the local public health departments, and others in the health care sector.

Response to public health programs like H1N1 is very dependent on the cooperation and joint activities of the State Health Department and the other groups that I mentioned, other state agencies, local health departments, our partners throughout the healthcare system, and this collaboration is one of the strengths of our public health system in New York and why we

believe we'll be successful in moderating the impact of this new pandemic.

The primary pillars of the H1N1 response include implementation of surveillance and laboratory testing for H1N1, community mitigation activities, communication with the public and ongoing communication with county health departments, hospitals, clinics, doctor offices, schools, and other partners in the healthcare system, and we're now, as the final pillar, beginning to engage in a wide spread vaccination effort as H1N1 vaccine starts to become available.

Since its appearance in April, we have learned a number of things about the new H1N1. First of all, it is not a 1918 style pandemic in terms of its clinical severity. The clinical spectrum of H1N1 is more similar to seasonal flu. We have also learned that there is little background immunity to H1N1 in the general population and, as a result, H1N1 spreads rapidly particularly in children and young adults.

Pregnant women have been identified as a population at increased risk of severe complications and as a result are

a priority group for vaccination.

Unlike the seasonal flu, we have seen relatively little infection in the elderly population suggesting that there may be some immunity possibly as a result of past exposure to related flu witnesses.

With widespread transmission, it is inevitable that some people with underlying medical conditions will experience severe illness and require hospitalization, and indeed we have seen this and a number of deaths.

It's also important to highlight as was a recent set of articles in the Journal of the American Medical Association just over the weekend that young adults without underlying medical conditions can also be heavily impacted. Those articles highlight the experience in the southern hemisphere with young adults needing ICU care without underlying medical conditions.

So it's important to note that seasonal flu kills on average 2000 New Yorkers a year, and our experience with that, and with the experience so far with H1N1 indicates that flu is not something to

be taken lightly.

In response to the questions in the hearing announcement, I first want to review the current H1N1 flu activity. Nationally, influenza activity attributed to 2009 H1N1 increased during September, beginning in the southern states where the school starts earlier in August than in the north.

H1N1 is expected to continue through the fall and winter season. In New York State, our surveillance systems outside New York City indicate that flu activity is starting to increase. New York's flu status has gone from sporadic to localized to regional to widespread over the last five weeks, with now over 50 percent of areas outside of the city reporting flu activity.

I want to highlight that this

is very unusual for this time of year. Typically, flu peaks in January and February. To date, this fall, the number of people hospitalized remains low but appears to be starting to increase. Rates of visits for influenza-like illness are also increasing at emergency departments and sentinel providers and several college

campuses have reported outbreaks with one death and college student reported.

So it appears that we may now be entering the beginning of our third influenza season this year. The first, the regular seasonal flu last February and March, the second, the H1N1 outbreak in May and June, and now potentially the return of H1N1.

However, we don't know for sure how the fall and winter seasons will unfold. A telephone survey conducted in New York City last spring found that between six and 10 percent of New Yorkers in the city experienced some influenza-like illness. Some should have speculated that this may

spare us from the return of an intense outbreak like we saw in the spring.

However, we do know that when a new pandemic strain appears, up to 35 to 40 percent of the population may be impacted in the first several waves of the pandemic. So we need to be prepared for an outbreak of that magnitude.

Next, let me address the H1N1 vaccine efficacy and safety. One of the

remarkable aspects of the H1N1 influenza response has been the development of vaccines to prevent it. Influenza A, H1N1 2009 monovalent vaccines have been developed by the same five manufacturers who make the seasonal flu vaccine. The production and licensure of H1N1 vaccines is being done by exactly the same methods and standards as the seasonal flu vaccines.

100 million Americans are vaccinated each year with seasonal flu vaccines, so the safety and efficacy of these vaccines are well defined. The only difference between the 2009 H1N1 influenza

and the seasonal vaccine is the specific H1N1 viral antigen contained in the vaccine, and I would highlight that the seasonal vaccine also contained an H1N1 antigen, not just the one that's causing the pandemic at this time.

The only other difference is that clinical trials have been done with the H1N1 vaccines to establish the dosing requirements. Clinical trials are not typically done with the seasonal vaccines, so we actually know more about the characteristics of the H1N1 vaccine than we

do about this year's seasonal vaccine about these trials.

Preliminary data from the clinical trials indicate that the immunogenicity and safety of the H1N1 vaccine is similar to that of seasonal influenza vaccines. The other good news from the clinical trials is that persons older than 10 years need receive only one dose of vaccine to be protected, and we thought that two doses would be required for

many adults.

To further assure of the safety of the H1N1 vaccine, New York is participating in expanded federal programs to monitor any possible adverse outcomes through a nationwide reporting system known as the vaccine adverse event reporting system through a program using managed care data on large populations to conduct follow-up of vaccinated persons, and through a separate CDC sponsored program to report Guillian-Barre Syndrome cases.

What is the availability of supplies and the plan for H1N1 vaccine distribution? There are currently four

companies fully licensed by the FDA to make the 2009 H1N1 vaccine. The CDC estimates that between now and the end of November there will be over 80 million doses of H1N1 vaccine available all purchased by the federal government.

State health departments, and in New York City, the City Health Department, are responsible for developing vaccine

allocation plans and placing orders on behalf of healthcare providers in their jurisdictions.

The Advisory Committee on Immunization Practices at CDC has recommended the following five priority groups for vaccination against H1N1, pregnant women, persons who live with or provide care for infants aged less than six months of age, health care and emergency medical service personnel, persons aged six months to 24 years, and persons aged 25 to 64 years who have medical conditions that might put them at higher risk for influenza-related complications.

These groups, priority groups were chosen either because they had a high risk of complications associated with the

flu or because they were more likely to come in contact with and possibly transmit flu to persons who are at high risk of complications.

Once vaccine has been made available to these groups, it is anticipated

that the priority scheme will be relaxed and eventually all New Yorkers who wish to receive a vaccine will have an opportunity to do so.

Our strategy to distribute the vaccine is to engage as many public health and healthcare providers as possible to make vaccines as widely available as possible as quickly as possible.

The State Health Department has developed a system to register all providers outside of New York City, and the City Health Department has done similar for who are interested in receiving vaccines.

To date, over 4,000 providers have registered outside of New York City. They represent a range of specialties and provider types including private practice physicians, hospitals, local health departments, federally qualified health

centers, pharmacies, colleges, universities, public health clinics, substance abuse treatment clinics, and Indian health providers.

We will continue to work with providers in the coming weeks to register as many as possible in this effort.

Each week, New York is provided a number of doses from the federal government that are available to order. We expect to receive our per capita share of approximately six percent of the national allotment. We were able to place the first orders for the 2009 H1N1 vaccine the week ending October 2nd and those vaccine doses were delivered around the state last week.

Initial availability of vaccine was limited to 91,000 doses of live attenuated vaccine to upstate and a slightly less amount for New York City. The live attenuated vaccine is licensed for use in otherwise healthy children, aged two to 24 years of age, healthy adults 25 to 49 who are healthcare workers, or who care for children under six months of age. Those are the groups for whom it could be used at this point.

Our initial ship-to sites focused

on hospitals, all hospitals, local health departments, and federally qualified health centers.

Outside New York City, in an effort to assure that persons in all parts of the state in these categories could have access to vaccine as quickly as possible.

Additional orders for 113,000 doses of vaccine were placed last week and are expected to arrive at designated sites this week. This will include the first doses of the injectable vaccine.

This is only the beginning of what is expected to be a substantial supply of H1N1 vaccine. We hope to be able to take the first orders from physician offices and pharmacies later this week or early next week. We anticipate that by early November, most providers who want to order vaccine will be able to do so, and the vaccine shipment will take place over the following several weeks.

One important message we need to convey is that this vaccine is now being

produced. People and providers need to be patient as we in public health and the healthcare system do our best to ensure that vaccine is first delivered to those who are in the priority groups.

Let me just now briefly address techniques to prevent spread of flu. Vaccination is the most effective way to prevent the spread of influenza, and I think that bears repeating. Vaccination is the most effective way to prevent the spread of influenza.

The next most effective measures are those that prevent contact with ill persons. The message to stay home from work or school when you are sick is one we cannot overemphasize and it's one we've been repeatedly getting out in every manner possible.

Healthcare settings are no different than any other occupational setting where vaccination is the most effective method for preventing influenza. And this is the rationale behind the

healthcare worker mandate for flu vaccination.

In healthcare settings, other measures such as the use of face masks by healthcare workers when in contact with ill patients, and for ill patients themselves when they are being transported are recommended. The State Health Department, the New York City Health Department and a number of other state health departments and national professional organizations, have made the same recommendations for face mask use for H1N1 vaccine as for the seasonal vaccine -- excuse me, H1N1 influenza as for the seasonal influenza.

There is controversy right now about whether high level of protections, so called N95 masks should be used for every contact with a patient with influenza-like illness or when aerosol generating procedures are undertaken, as we recommend.

We expect CDC to issue revised recommendations as early as this week and hopefully we'll be able to move forward with

a single set of recommendations.

New data on the efficacy of face masks is becoming available almost on a weekly basis. A study in the Journal of the American Medical Association two weeks ago represents the first well-designed randomized controlled trial of its kind comparing N95 masks with surgical masks for nurses for routine care of patients with influenza-like illness.

The study found no difference in influenza infection rates in nurses using randomized to use the N95 versus the surgicals masks in the 2008-2009 flu season.

22 to 23 percent of each group developed influenza, signs of influenza illness or anti-body evidence of influenza infection during that season, almost one in four developed flu in both groups.

This suggests that N95 masks by themselves may not provide any additional protection in routine patient care settings. The editorial that accompanied the article stated that masks should only be used as a

last line of defense against influenza and I think this highlights what's perhaps the most remarkable finding in the study, that with one in four healthcare workers infected

with the flu, only 30 percent in either group have been vaccinated for flu.

How is the department assisting healthcare settings, schools, workplaces, and others in implementing protective measures? At the direction of the governor, the State Health Department in collaboration with other state agencies has developed numerous resources intended to assist employers, schools, businesses with the implementation of procedures to help prevent and reduce the spread of flu.

These resources include model policies on attendance and sick leave. Contingency plans for businesses in the face of high staff absenteeism and guidance for schools and businesses on communicating flu prevention messages to their employees, students and family members.

The State Health Department has

worked closely with the State Education Department in developing guidance for schools.

Finally, in terms of outreach to the public and providers, as the 2009 school year approached, the governor asked us

again, the state agencies to work proactively to reach out to communities and to individuals throughout the state to provide education. To date, approximately 2,100 planning and preparedness set partner sessions have occurred to -- including state agencies, hospitals, local health departments, long-term care facilities, community health centers, home care and hospice staff, schools, universities and business groups.

The State Health Department holds weekly teleconferences with representatives from the local health departments, separate teleconferences with hospitals and long-term care providers, and is planning to provide webinars, the first being held today with the pediatricians and the American Academy

of Pediatrics. Webinars are direct meetings with various groups of providers. For example, we've worked closely with the American College of Obstetrics and gynecology to identify the best way to get H1N1 information to pregnant women and their healthcare providers.

We have overhauled our website. It has a new design and are engaged in mass

media campaign to educate people about the ways to reduce their chances of getting or spreading the flu. A two-week radio buy was timed to coincide with the back-to-school period. A television PSA with a similar message has been distributed statewide. It is getting good air-play.

A radio PSA featuring a pregnant woman explaining why she'll get H1N1 vaccine will be aired shortly. Finally, later this month, the department will begin an advertising campaign posted on mass transit in many parts of the state to encourage vaccination.

Finally, we do know that with

flu, the one certainty is uncertainty. We need to remain vigilant and flexible as to this evolving situation. We will continue to communicate and coordinate with our public health and healthcare partners throughout the state to assure that our response is successful in preventing flu in the first place or easing the recovery of persons who develop illness.

Thank you very much.

CHAIRMAN GOTTFRIED: Thank you.

I have a series of questions.

I'm concerned about the absence from your testimony and from a lot of material that I've seen so far to any significant discussion of the importance of keeping up one's resistance through nutrition and rest and the efficacy of frequent hand washing and use of sanitizers as critical measures in reducing one's own exposure and one's transmission to others.

Could you comment on that and will those messages be part of the Health Department efforts and why do I have the

sense of not having seen that?

DR. BIRKHEAD: Well, certainly the hand washing message is one that we've gotten out widely, I think it's on our website. It's in every press release where we list the measures to prevent transmission. So hand washing has definitely been part of the message.

In terms of general nutrition, I think that's always a good health message. I think we're trying to tailor our messages to areas where we have evidence base that they actually will be effective in preventing, and I think there's not an

evidence base in terms of prevention, so we've not focused on that.

CHAIRMAN GOTTFRIED: In other cultures or other countries where there has been concern about influenza, you see work sites putting up, you know, sanitizer dispensers on the wall, you see posters in transit facilities and on the street.

I mean, most of us never see the Health Department website or a Health

Department press release. It would seem to me it would make a lot of sense for New Yorkers by now to be inundated with seeing posters and radio and TV messages about hand washing.

Is that in the plan?

DR. BIRKHEAD: Well, Assemblyman, I think it is in the plan and it's already happening.

As I mentioned, we've been conducting radio spots. We have a TV spot that's been running that makes exactly the point you're making. In Corning Tower where I work, dispensers that have been installed by all the elevators on every floor, so I think that is happening.

CHAIRMAN GOTTFRIED: Well, in some state buildings perhaps.

DR. BIRKHEAD: Well, let me just add that we have, as I mentioned, have developed a tool kit for employers that includes the posters you indicate and other messages, and model policies, so these have been distributed pretty widely.

CHAIRMAN GOTTFRIED: Okay. In terms of the radio ads and other ads, you mentioned them stressing, in your testimony, the importance of vaccination.

Do they also have a prominent message about hand washing?

DR. BIRKHEAD: Actually, the vaccination ads have not run yet. The ads that have run are the general preventative ads. The TV spot is a classroom with a child passing forward a homework paper from the back of the room and demonstrating, through the use of a green glow, how germs can spread in that way.

So the message there is stay home if you're sick, wash your hands. That is the message that's running now.

CHAIRMAN GOTTFRIED: Okay. The Health Department regulation requiring

healthcare workers who have direct patient contact, and other workers who have contact with workers who have direct patient contact, is cast as a requirement on the employer, that the employer shall require

each worker to be vaccinated. So it is directly a mandate on the employer, not directly a mandate on the individual worker.

Can you discuss for us a little, what measures an employer will be expected to exercise under that mandate, to be able to tell the department, yes, I am requiring?

Just to sort of give an example, you know, we have a law that requires children under a certain age or weight in a car to be -- to have -- to be in a booster seat.

If a trooper stops someone on the thruway and they have a child in the back seat without the booster seat, the enforcement is not to stop the car, make the child get out, stay by the side of the road and send the parent on. At least, I hope they don't do that. They give the driver a ticket and send the driver on.

What will be the measures that

hospitals and others will be expected to exercise in order to comply with their mandate?

DR. BIRKHEAD: Let me say as a starting point that, for reference, that we view this as a patient safety measure and that it builds on existing requirements in state regulations for healthcare workers to receive measles and -- demonstrate measles and rubella immunity which have been in place for almost two decades, and for annual TB testing that has in place longer than that.

That the basis of it for the healthcare workers, it's the section of regulations that deal with the health care workers demonstrating that they don't present a health risk to their patients.

So the framework that we've built upon is one that's very familiar to the hospitals. You're correct in saying that the Health Department is regulating the hospitals and other healthcare agencies, not the individuals, and we do that through our Department of Health staff who visit hospitals, and when they do review the policies and procedures that are available,

and in this case would also view some records, patient -- employee records to demonstrate that the vaccination was done.

The regulation also calls for the hospital to file a report with the Health Department by May 1st, demonstrating -- and the details of that report are being developed, but essentially demonstrating the coverage level.

So the short answer to your question is, this will be enforced in exactly the same way as the existing healthcare worker mandates are enforced.

I think the facilities are familiar with how the Health Department does business in terms of reviewing both protocols and policies when they make site visits, as well as examining a sample of records. So that is how it will be carried out.

If the facility is found deficient, a statement of deficiencies will be issued and the facility will develop a plan of correction to deal with that. So

that's the general framework under which this regulation will be enforced.

CHAIRMAN GOTTFRIED: Another question which I ask largely because I imagine there may be other witnesses who will ask.

Can you tell us what Commissioner Daines' personal plan is for being vaccinated for both the seasonal flus and H1N1?

DR. BIRKHEAD: I think I can speak for myself and I believe this applies to Commissioner Daines, we're scheduled to get our seasonal flu shots this week and we will get the H1N1 vaccination at the time when it's indicated based on our priority group.

CHAIRMAN GOTTFRIED: When you say "at the time indicated," could you elaborate on that?

DR. BIRKHEAD: Right. At this point, otherwise healthy adults are not recommended, unless they're in a healthcare setting, so --

CHAIRMAN GOTTFRIED: Please.

DR. BIRKHEAD: Let me just clarify. I intend to get the H1N1 vaccine. My wife is a nurse, she intends to get it, and our kids are also going to get it.

CHAIRMAN GOTTFRIED: And is the timing question one of whether there is an adequate supply and whether one is in a priority group, is that the issue?

DR. BIRKHEAD: Correct. Mostly the priority group issue. I think the supplies will eventually be sufficient.

CHAIRMAN GOTTFRIED: Okay. Can one get or should one get the two shots on the same day, or should they be separated?

DR. BIRKHEAD: No. The injections can be given on the same day. The live attenuated virus should be separated, the vaccine should be separated by four weeks.

CHAIRMAN GOTTFRIED: Separated from?

DR. BIRKHEAD: If you're giving two, the seasonal live attenuated and the

H1N1 live attenuated, those should be separated by four weeks. Otherwise there's

no restriction on the timing.

CHAIRMAN GOTTFRIED: And the live attenuated is the nasal mist?

DR. BIRKHEAD: The nasal spray, correct.

CHAIRMAN GOTTFRIED: In terms of groups that should be particularly vaccinated in your judgment, one question that I would have is teachers, and whether if what the argument would be -- and I guess it may or may not be within the Health Department's legal jurisdiction.

From a public health view point, how would you compare the importance of teachers being vaccinated with healthcare workers?

DR. BIRKHEAD: Again, we're following the CDC and the federal guidance recommendations really in terms of choosing the priority groups. There was quite a bit of discussion at the Federal Advisory Committee, if this had been a 1918 style

pandemic, we would try to be getting vaccines out as widely as possible to age groups, but it's not a 1918 style pandemic.

So the priority groups are really those with underlying risk factors that

would place them at risk of complications should they get the flu and, also, individual healthcare providers who were particularly highlighted in the priority setting in order to maintain the health care system and also to protect patients from acquiring flu in healthcare settings. So that's the basis of the federal guidance.

Teachers would be eligible for vaccination if they, themselves, were at risk for underlying complications, or if they care for children under six months of age in a daycare setting, for example, but otherwise, teachers were not viewed by the advisory committee at CDC as being different from other occupational groups in that sense.

CHAIRMAN GOTTFRIED: Okay. Those are my questions. Deborah?

ASSEMBLYWOMAN GLICK: Really just one question. The notion that there should be a vaccine available to those who have underlying conditions.

Now, in the spring, there were a few high-profile illnesses and then subsequent deaths and, in each instance, the

news report was whoever the individual was had an underlying healthcare problem. An underlying disease issue.

Perhaps because of the privacy for the individuals, there didn't seem to be more specific information generally available. I'm not talking about going to websites or anything, if you're listening on the news. And I was just wondering what are the underlying potential health complications, so that people in the general public have a clearer understanding of whether they or somebody in their family is potentially at risk?

Somebody in my age group generally is not viewed as having a particular risk except if you have an

underlying condition and then everybody wonders what exactly does that mean, is it certain kinds of heart disease, what are they?

DR. BIRKHEAD: It's a wide range of chronic illnesses which would include heart disease, lung disease, particularly asthma in kids was found to be a risk factor for hospitalization and poor outcome, but it can range from diabetes to other chronic

diseases.

Certainly someone with immune suppression from cancer, cancer chemotherapy or HIV would fall into a risk group. So it really is a broad of chronic conditions that impact one or more systems, cardiac, lung, metabolic illnesses like diabetes, and there's pretty good evidence that this places one at increased risk of poor outcome, complications, hospitalization, and we saw that quite clearly in the data that we collected and were collected nationally in the spring. That those were the groups most likely to end up in the hospital.

There was the exception of the under fives. Kids under five are generally -- did not need to have -- did not have high rates of underlying chronic conditions, and that I think speaks to the influenza impact on that age group, particularly. So it's a wide range of chronic conditions, a debate in the medical literature around whether a morbid obesity is a factor as well, and it appears that that may be an independent factor for poor outcome.

So CDC, in the guidance, has laid

out a large list of the conditions that I've mentioned and that's what we're trying to get the word out about.

ASSEMBLYWOMAN GLICK: Well, in some parts of New York City, particularly around transit facilities, bus depots, there is a pretty high rate of asthma and there are hot spots. Lower Manhattan has become a hot spot partly because of heavy traffic, and partly seemingly, although nobody actually wants to say this post 9/11, there's been a spike in asthma.

Many people, adults, who never had an asthma issue, have developed that. I'm just wondering if there's anything that the department is doing in conjunction with the City Health Department around those hot spots where we know there is a high degree of asthma, not just childhood asthma but adult asthma?

DR. BIRKHEAD: You mean in terms of targeting messages around vaccination?

ASSEMBLYWOMAN GLICK: Well, what communication have you had with the City Health Department related to that?

DR. BIRKHEAD: We've been working very closely with the City Health Department

and we've had a number of all-hands-on deck staff meetings to do it and this is one of the issues that have come up. I can't speak specifically to what steps are being taken around asthma in the hot spots, but that's definitely a group that we would want to be able to reach.

ASSEMBLYWOMAN GLICK: Let me just say that I don't think that anyone in my

community has gotten a particular message around that, even though we have an enormous number of people who are now regularly on inhalers as a result of whatever their exposure was, whether it was traffic induced in a particular corridor, or whatever.

So perhaps that might be something that the department might go back to the City Health Department and talk to them about.

DR. BIRKHEAD: We can certainly look at that.

ASSEMBLYWOMAN NOLAN: Just quickly, and it's a pleasure to do things in a collaborative way in the legislature and take our cues from Assemblyman Gottfried's great leadership in the Health Committee.

So it's a pleasure for me to get to ask you a question.

I just wondered from my point of view because, at education, it seemed to sort of come out of nowhere and I realize that that's probably not the case.

But just describing it, not only

as a member of the legislature, but as a parent of a school-aged child in New York. So how surprised was the Department of Health, in other words, how do you feel that your agency responded quickly, or reacted, or -- because, you know, so often and perhaps we get a skewed view from the media that a hard-working nurse at a school somewhere is the first discover West Nile this or swine flu that, and I'm sure that may not be the whole story and the media will focus obviously on something like that because it's good human interest, but were you surprised?

How did the Department of Health begin to realize we were dealing with this situation?

DR. BIRKHEAD: Well, the outbreak at the school made it pretty obvious that two days following the first reports out of

Mexico that we had something unusual happening here. I mentioned in my remarks that we undertook pandemic flu planning for the last three years, and we have actually

had sessions with school superintendents, principals a year or two ago on the steps that would need to be taken in the event of an influenza pandemic, including closing schools, and arranging for kids to work from home.

Those plans were looking at a category five, 1918 style pandemic, where we might need to close schools for six weeks. We clearly didn't need to do that. In fact, I think as soon as the initial reaction to close schools immediately on a few cases was triggered by not knowing the full spectrum of severity of this and, once that became clear, we backed off now and school closure is not really recommended as a public health measure.

It may be necessary as an educational message if the educational mission can't go forward, but we have actually developed with the State Education Department and, as I say, have had a number

of table-top exercises and meetings over the years with school personnel, nurses,

principals, superintendents around how to deal with exactly this kind of thing.

So I think we felt reasonably well prepared and the kinds of plans and efforts underway now are very similar to what we talked about then.

ASSEMBLYWOMAN NOLAN: So you felt it played out in the way you had envisioned?

DR. BIRKHEAD: Well, things are never exactly as envisioned. I think the degree of transmission in school-aged kids was something --

ASSEMBLYWOMAN NOLAN: Surprising, right?

DR. BIRKHEAD: Was something that got everybody's attention, and I think that's the concern that we haven't exhausted that pool yet.

ASSEMBLYWOMAN NOLAN: I will say, because Queens was sort of an epicenter. I represent part of Queens County and it seemed to move so quickly, and, yet, my son's school had not cases, no problems, and the school not far away seemed to have

dozens.

So it was very frightening as a parent, how could that be, how could that be explained, and I think that from my own, I hope that the department and the various education departments will do more to educate parents as to how that could have been. Because in some ways, the sort of jumping around nature of it, school X had a hundred kids out, school Y had no kids out, that made people more nervous. It wasn't the same as measles, and thank God we don't really deal with that anymore, but it wasn't the same as a cold and everybody seemed to get it in the same way.

So I think there's still a high degree of anxiety among New York parents and I think the department needs to factor that in as they go forward.

DR. BIRKHEAD: Okay. Thank you.

CHAIRMAN GOTTFRIED: Rory Lancman.

ASSEMBLYMAN LANCMAN: Good morning. Thank you for your testimony. I

appreciate the opportunity to be able to ask you some questions.

I want to focus on three areas. The vaccine, particularly the mandatory vaccination program, the issue of N95 respirators which you also touched upon in your testimony, and to the extent to which government agencies and private employers are doing adequate planning to prevent H1N1 in the workplace.

Regarding the vaccination issue, I would like to get to the heart of the decision making on the commissioner's part to make this vaccination mandatory.

Now this is a very fluid situation, the H1N1 pandemic, and I understand that information is constantly being updated, being changed, and agencies are trying and governments are trying to adapt their strategies accordingly.

But, if I'm not mistaken, New York State is the only jurisdiction in the country that is making these vaccinations mandatory.

I know that the CDC, when Dr.

Friedman was asked whether or not he intended to recommend mandatory vaccination, he said that he would not, and Dr. Friedman was formally the New York City Department of Health commissioner. So he certainly is someone familiar with the situation here in New York.

Am I correct that there are no other jurisdictions in the country that are recommending the mandatory vaccination?

DR. BIRKHEAD: I'm not aware of any that have a legal requirement at this point, no.

ASSEMBLYMAN LANCMAN: What is the science behind the mandatory part of the vaccination? What do we know that the rest of the country doesn't and, if we're leading the way in the right direction, great, I'm proud to be a New Yorker, but I want to know that this was a decision made based on something more than a gut feeling on the commissioner's part?

DR. BIRKHEAD: So let me go back

and just say that this mandatory requirement for healthcare workers originated almost two years ago.

The decision at the Health Department to pursue this in November of 2007, I presented to the State Hospital Review and Planning Council and to the State Public Health Council. The evidence that we had from our experience in New York, as well as the evidence in the medical literature around healthcare worker vaccination, and we actually started the process at that time for hospitals. It was a regulatory process. Working through the State Hospital Review and Review Planning Council, and I'll just comment that the state hospital, not just the Commissioner of Health that has done this, but the State Hospital Review and Planning Council, a 30 member appointed body, which has representatives of all segments of the healthcare sector including consumers et cetera. And this group has unanimously voted in favor of this approach. That was the regulatory approach we needed

to do in hospitals.

For nursing homes, we have Article 21A of the Health Law which was adopted in 2000, which requires the offering of vaccines to healthcare workers and we could not do a mandate by regulation, so

last legislative session, the department did propose legislation which the legislature did not move forward to extend the mandate.

So we've been pursuing this for almost two years. It was developed way before H1N1 was even thought about and it's based -- you ask what's evidence based on? It's based of years of trying get to healthcare workers vaccinated for flu unsuccessfully, and what I will highlight is Article 21A which required the facilities to report to the Health Department, these are nursing homes primarily, the coverage levels of their employees.

When 21A passed in 2000, we began a series -- the City Health Department joined in with us of educational efforts to -- at long-term care facilities. We

provided tool kits. We did on site, in-service sessions. We pulled out the stops in terms of materials, Q and As, et cetera, for a period of years.

This went on through the early 2000s and each year we measured the coverage rates of employees in those settings. We actually did very well in terms of coverage

amongst the patients. We were up to 80 to 90 percent of patients getting the flu shot each year, but the employee levels and, these are reports to the legislature that we sent each year, indicate roughly about 30 percent on average healthcare workers getting vaccinated in these settings, year after year after year, despite intensive efforts to make this happen.

And, in the face of that, continued outbreaks of disease, we know that the elderly, particularly and chronically ill, may not respond with protection from vaccination, and this is clearly been borne out in those settings where we continue to have hundred to 200 outbreaks a year,

thousands of patients ill, deaths, hospitalizations from flu, and not just our experience, but I think in the medical literature, a recognition over the last decade that healthcare workers can transmit flu, they are a tough bunch, they work when they're sick, or they can transmit flu even if they're not experiencing severe symptoms and it's -- the issue of transmission of flu in healthcare settings where you congregate your most vulnerable patients to provide

care is a significant one that's gotten attention.

The CDC has recommended all healthcare workers get flu vaccinations since 1981, and many places around the country have been trying to do this and we've just simply been unsuccessful.

ASSEMBLYMAN LANCMAN: Since the CDC since 1981 has recommended that all healthcare workers get vaccinated, why hasn't the CDC taken that extra step, a step that without -- I think without overstating, it is radical. It's unique in the country.

Why hasn't the CDC --

CHAIRMAN GOTTFRIED: Excuse me. We have a long day ahead of us. There are going to be a lot of people inclined to respond to a lot of statements by witnesses. We can't have that.

ASSEMBLYMAN LANCMAN: So I assume the CDC has -- and other jurisdictions have gone through some kind of risk benefit analysis.

Has the department done that and what are the risks and how are they overcome by the benefits?

DR. BIRKHEAD: There's plenty that's been written about the risk and benefit. The risks are small in comparison to the benefits. The benefits are fewer cases of flu transmitted in healthcare settings.

There's also a cost benefit to the facilities to have high rates of staff coverage. Facilities actually spend a lot of money high hiring agency nurses or paying overtime during flu season every year, and

there are a number of studies in the medical literature showing that higher rates of flu coverage in workers would allay those costs, so both on a human cost as well as a monetary cost, I think the benefits are clear. CDC does not make recommendations on mandates.

I think you're all familiar with school mandates. CDC does not recommend school mandates. They say that's an issue for the states. And that is what they say on this matter as well.

There are a number of national professional organizations. The infectious diseases, Society of America and others recommend mandatory vaccination for

healthcare workers and a number of large healthcare systems around the country have moved to some form of a mandatory program.

So, your question, you know, is this radical, we added this on to the existing measles, rubella, and TB requirement which many states have, and I think we have had a lot of interest from

other states since moving forward with our proposal.

So we may be in the lead. I mentioned to Assemblyman Gottfried that the legislature this year passed a requirement that families of patients, infants in newborn intensive care units be offered vaccine. That's also something no place in the country does.

So we in New York are at the forefront of trying to control flu in our population because of the impact that it's had.

ASSEMBLYMAN LANCMAN: You referenced the risks, I asked you about the risks and you mentioned them, but what are the specific health risks to somebody who is who is getting the H1N1 vaccine?

DR. BIRKHEAD: As I mentioned in my testimony, we administer about hundred million doses of flu vaccine in this country each year and the risks are well known. The contraindications are for individuals with egg allergy or severe prior allergic

reaction.

There may be a very low rate in some studies, one in a million of a form of paralysis called Guillian-Barre Syndrome, but I think that's not for certain, but flu influenza itself causes five to 10 times that rate of that illness. So the vaccine is a benefit even with a very low level of risk.

ASSEMBLYMAN LANCMAN: Well, I'm trying, you know -- you're from the Health Department, so you certainly have expertise, but we're hearing different things from so many different organizations and different groups. You know, when the commissioner put the word out that there was going to be mandatory vaccinations, he wrote in his letter of September 24th, and, you know, it's unfortunate that you've got to answer for the commissioner's terms, but I want to understand it because I assume it's

department policy.

He wrote, "This is not the time for uninformed or self-interested parties to

attempt to pump air into long deflated arguments about vaccine safety in general, or to use a single 33 year old episode to deny decades of safety and saved lives achieved by influenza vaccines prepared in the same way as this year's formulation."

Before I get to the single 33 year episode, who were the uninformed or self-interested parties that the commissioner is complaining about?

DR. BIRKHEAD: I think it's the general gist in the blogisphere from, you know, from folks who are opposed to vaccination. There's not a specific individual that the commissioner had in mind.

ASSEMBLYMAN LANCMAN: Well, I hope that it will get back to the commissioner through yourself and the others who are here from the department that that kind of characterization of people who have legitimate concerns about vaccinations is not really helpful to the dialogue.

25 But what is the 33 year old

episode that the commissioner's talking about? Is that the 1976 situation?

Why don't you explain it to me from a health perspective because I've heard a lot about it. What happened in 1976 with the -- what was then politically acceptable, I guess to call the swine flu vaccination --

DR. BIRKHEAD: Yeah. In 1976, a new strain appeared in a few cases in a military preserve in New Jersey. It was a new strain that they thought at the time resembled the 1918 strain in some ways. They embarked on a national vaccination program, despite the fact that there were no cases of this influenza occurring in a population as a precautionary measure, they did vaccinate about 45 million people.

The program was stopped when there was a concern about higher rates of Guillian-Barre Syndrome, a form of paralysis. There have been a number of studies since that time. I think the jury is still out on actually whether there was an increase related to the vaccine. In any

event, that vaccine was made by a somewhat different method. It was -- the whole virus was included in the vaccine inactive where as now we use a sub-unit vaccine.

So in the year since that time, this has been obviously an important question to study. There have been a number of large studies looking at it. Many of the studies show no relationship between flu vaccine and the syndrome.

There are a couple of studies that suggest a potential increased risk of one in a million above baseline, and I will comment that in New York each year, we get four to 500 cases of Guillian-Barre Syndrome as a background rate. We have 25 to 40 cases a month in the state.

If you look seasonally, it's mostly in the winter months, January, February, March when flu and other viruses are circulating and we do know that infections and particularly a form of gastro-neuritis infection can cause this form of paralysis.

We don't see, interestingly, increased rates in the fall when flu vaccines are given.

So I think if there is a risk and that, I think, scientifically is in question, it's a very small risk, and pales in comparison to the benefits. As I mentioned, flu, the infection itself, can cause -- is believed to cause this form of paralysis so the vaccine prevents more cases than it might possibly cause if indeed it causes any.

ASSEMBLYMAN LANCMAN: I just want to clarify. I mean, I do understand that there might be certain risks associated with vaccines or any healthcare policy. I mean, but the CDC seems convinced and this is what the CDC says, that there is some connection between this Guillian-Barre and the flu vaccine.

What the CDC says is that the Institute of Medicine conducted a thorough scientific review in 2003 and concluded that people who received the 1976 Swine influenza

vaccine had a slight increased risk for developing GBS. And then somewhere else it

put that risk at about one per 100,000 people vaccinated.

Now that may be an acceptable risk. I'm not sure but I would leave that to the health experts, but I just think it's very important that people understand that risk.

DR. BIRKHEAD: That statement was for the 1976 vaccine.

ASSEMBLYMAN LANCMAN: That was my next question.

DR. BIRKHEAD: If you read further in the CDC, they will say that the more recent vaccines have been studied intensively, many studies have shown no relationship.

There are a couple of studies which show a potential increase risk in the range of one in a million doses, and CDC -- I mean, that's basically their statement on the current state of knowledge at this point.

ASSEMBLYMAN LANCMAN: So basically, the answer is more or less --

DR. BIRKHEAD: And flu itself can cause five to six per million cases of the

paralysis.

ASSEMBLYMAN LANCMAN: But the basic response to the 1976 incident is this a different vaccine?

DR. BIRKHEAD: It is made in a different fashion. It contains less material, and it -- only the material that causes immunity instead of the whole virus which was put in in 1976.

ASSEMBLYMAN LANCMAN: What kind of consultation did the Department of Health have with employee representatives, with unions with employees? I've gotten some very very bad feedback, very negative feedback from employee organizations saying that they were not consulted and, frankly, when they met with Commissioner Daines on the issue, they were told that their input was not particularly welcome.

So what kind of consultation did

the department undertake before it implemented this emergency regulation?

DR. BIRKHEAD: As I mentioned, this has been under discussion at the State Hospital Review and Planning Council for several years.

Last fall, we also held a

roundtable at the Health Department where we invited representatives to come and have a discussion, at that time mostly around the long-term care bill, but I think it was clear in that session that we were talking about both the regulatory and the long-term care approach.

There may have been other contacts that I'm not aware of, but those are the things that I've been involved with.

ASSEMBLYMAN LANCMAN: Well, I would just suggest to you, and if this could get back to the commissioner, that there -- from what I've observed and from what I have heard, there is a very strong feeling of not being a part of the process, of not being consulted in a process that resulted in a

decision that healthcare workers take very very seriously.

And going forward, the commissioner should give serious consideration to improving that consultation process. You may never get the employee advocacy organizations, the employee organizations, the healthcare workers to agree with your decision, but from my

perspective, it seems clear that there just has not been enough input and consultation and collaboration, which is a word you used in your testimony several times with the people who are most impacted by the mandatory vaccination decision.

Why no religious or philosophical exemption for people who have such reservations?

DR. BIRKHEAD: Well, again, we built this on the existing framework of measles, rubella, and tuberculosis testing and other requirements for healthcare workers for which there is no religious exemption. At its base, it's a

patient-safety issue and it didn't seem appropriate to have that be a part of this.

I mean, the basic answer is that it was not a part of the regulatory framework that we added this onto.

ASSEMBLYMAN LANCMAN: Do you think that if there were an exemption there would be a very large percentage of employees? I mean, I just wonder how many employees have really exercised the right to claim a philosophical or religious exemption and what would the real impact of that would

be on the effectiveness of the vaccination program? I would think it would be a small percentage.

DR. BIRKHEAD: It's very hard to say. I don't think we have good information about that.

ASSEMBLYMAN LANCMAN: Would you consider trying it and seeing how it goes?

DR. BIRKHEAD: That's not the approach that we're taking at this point.

ASSEMBLYMAN LANCMAN: Well, again, if you can take back to the

commissioner some consideration --

ASSEMBLYWOMAN NOLAN: I just want to make sure -- that is not, for example, my position. I would be very concerned if I was in a hospital bed as a vulnerable patient, my relationship with the healthcare provider, which I may not choose that person, I might be sick and brought in, so I just want to make sure we have a hearing, and I try not to take my own positions.

I'm here to just listen to what people have to say, but for me personally I would not want my presence at the hearing to be construed as supporting some kind of

exemption on a mandatory issue. I just wanted to make that clear.

I, myself, am comfortable with what the department has done, but always want to hear what people have to say. It's one reason I came to the hearing. I see downstairs they there were picketers and things so obviously not everyone agrees with where I'm coming from, and I want to try to have an open mind as possible, but I -- I

appreciate where you're going with this, but it doesn't speak for me.

Just so that the record shows everybody has their own view.

ASSEMBLYMAN LANCMAN: I didn't think it was necessary, but I should have made a statement at the beginning of my questioning, my questions are only my own.

I want to ask you about the Health and Hospitals Corporation, their implementation of the mandatory vaccination policy.

As I read the emergency regulation, it requires hospitals and healthcare facilities that are covered by it to make some kind of judgment or evaluation as to which employees in a facility should

get vaccinated and which do not have sufficient patient contact or contact with people who might have patient contact, people who have potentially influenza-like illness.

But it's my understanding that the Health and Hospitals Corporation's

position is that everyone in the building is getting vaccinated and, if that is the case, and I can read you the regulations if you need me to, I can read you the Department of Health's, and I can read you the HHC guideline on who is getting vaccinated, but if it's the case that HHC is just right off the bat saying everybody in the facility has to get vaccinated, without doing an individualized or department-based analysis of who has enough patient contact or who has enough contact with people having patient contact, would HHC be exceeding the Department of Health's mandatory vaccination requirement?

DR. BIRKHEAD: I can't really speak for HHC. I don't know what analysis they have done of their situation. So it's very hard for me to comment on that.

ASSEMBLYMAN LANCMAN: Let me just read you HHC's -- it's just a couple of lines, let me read you HHC's guideline on this.

This is from a letter sent to the

facilities on September 2. "What are the rules? Who has to be vaccinated?"

Answer, "Everyone who works at a HHC hospital, diagnostic and treatment center, community based clinic, or as an HHC health and homecare provider must be vaccinated."

"These rules don't just apply to doctors or nurses or recall other health care personnel, they apply to everyone who comes into direct contact with patients who comes into regular contact with other workers who are in direct contact with patients such as housekeepers, volunteers, hospital security, technicians, clerks and administrators."

Although that is more restrictive somewhat than what the Department of Health says, it's my understanding and, if I'm contradicted by testimony later today from the city or HHC, so be it, but it is my understanding that HHC is applying this so

that every HHC employee in the facility from the frontline nurses and doctors to the

people down in the maintenance rooms in the basement, are required to get the vaccine.

Is that -- assuming that's the case, isn't that going beyond what the Department of Health has required?

DR. BIRKHEAD: Actually, I don't think so. The regulation as you stated applies to people with direct patient contact and with contact with others who have direct patient contact, and it may be that they felt in their facility they can't distinguish those groups out. The regs specifically mention, you know, the potential of off-site locations where there would be no such contact, but I think it is purposely framed broadly because we're trying to prevent illness from, you know, flu from impacting the facility and it doesn't have to be direct. It can be from one person to another to the patient, and so it's purposely framed broadly.

The other thing I would say is it's the same -- it's the same group to which the other requirements already apply.

And volunteers and others who work in facilities are already covered by the measles, rubella, and TB testing requirement because we've had experience with those diseases impacting through an indirect route.

ASSEMBLYMAN LANCMAN: As you understand the State Department of Health regulation and how it's supposed to be applied, do hospitals that are covered by it, are they required to determine which employees fit within those categories of those who should be vaccinated and make an effort to distinguish who should be or who shouldn't be, or would it be acceptable for an employer to just ignore that and say, look, we're going to vaccinate everyone in the building.

I just wanted to understand what it is the State Department of Health is required of employers?

DR. BIRKHEAD: I think the language of the reg is pretty clear about what the facility needs to -- I mean,

there's a group defined to whom the regulation applies and, you know, there may be some judgment or analysis needed at facility level to determine that. If the determination is that they can't distinguish a group, then the regulation applies to everybody.

ASSEMBLYMAN LANCMAN: Let me move on to the respirator issue quickly because you did address it.

Am I correct, as it stands now, there seems to be a conflict between the CDC's recommendation on who should, in a healthcare setting, who should use a respirator or when they should use a respirator, and the State Department of Health, that is correct?

DR. BIRKHEAD: Yes.

ASSEMBLYMAN LANCMAN: But how is that conflict going to be reconciled in the next week? That's what you said, right?

DR. BIRKHEAD: Right. At the federal level they've gone through a process, the Institute of Medicine convened

a group to advise CDC. CDC's received that advice, Dr. Friedman, who you mentioned is the now director at CDC. We understand that they are forthcoming. It's been anticipated now for several weeks, but within the next week or two, CDC will release revised guidance on this issue and we will certainly take a look at that.

As I mentioned, we, the City Health Department and a number of other groups have taken the position that the requirements for masks for seasonal flu are adequate for the H1N1 flu.

I think what happened back in the early days in April was that we were taking very extreme measures in a variety of settings, for example, closing schools on a single case and using N95 masks for any patient contact, and when it became clear that the clinical spectrum, as I mentioned, was not as severe for H1N1, we backed off, a number of places backed off in advance of CDC, I would say New York State and the city and others backed off to close school on a

single case several weeks before CDC backed off on that.

And, in general, we backed off on

the mask requirement to be the same as for the seasonal flu. The paper that I sighted which was not available at the time but has come out since in response. You know, the Institute of Medicine study, one of its main conclusions was that we need more data.

We're sort of operating in a data-free zone here, and the paper -- I think it's really one of the first really well-designed, as I said, randomized trials of this issue indicated that additional protection for routine patient contact with a patient with ILI did not yield any benefit.

But all that said, I think we realize that there's a conflict and that's placing the hospitals particularly in a difficult situation. So we're hopeful that the CDC guidance that's going to be forthcoming will address the issues in a way that everybody's comfortable with and we'll

be able to put this issue aside and move ahead.

ASSEMBLYMAN LANCMAN: My last question, regarding the kind of planning that is required of employers, public

employers, private employers, what kind of jurisdiction or effort does the Department of Health have to require that public agencies at least public agencies produce some kind of H1N1 prevention plan?

One of the things that we found in our report and the study that lead up to the report was, of course, healthcare workers have the most risk, but there are other occupations, correction officers in certain settings, teachers, who have an increased risk of exposure to H1N1 as well.

Would it be helpful if there was a requirement that all public agencies had to produce an H1N1 plan, or would that be overkill?

And, to your knowledge, what could or should the Department of Health do to help facilitate that?

DR. BIRKHEAD: Well, to answer your first question, I don't think the State Health Department currently has the jurisdiction that you're talking about. However, we have worked through the Governor's office at the state level, all the state agencies have received instructions around H1N1 and, as I

mentioned, we have several years of pandemic flu planning, what's called continuity of operations and other kinds of planning that we've been doing with the state agencies.

So these materials that will be helpful to them around H1N1 have been distributed. I'm not sure that they're developing a written plan, but they each are working through the issues and taking steps at the worksite. And that's really the scope of our formal activities there.

We have, over time, worked with the business community to develop an employer work tool kit, a workplace tool kit around flu prevention in general, and that has been widely distributed and is out there

for people to use if they want to.

ASSEMBLYMAN LANCMAN: Yeah, so how are you getting the employer tool kit, that sounds like it could be very helpful. What steps is the department taking to get the information out there that employers might be able to get this employer tool kit, because, until today, I haven't heard about it?

DR. BIRKHEAD: This is actually

something we produced several years ago in preparation for pandemic flu planning. It was set out widely through business groups on our website, et cetera, and we're undertaking efforts to get that out again.

ASSEMBLYMAN LANCMAN: I would just suggest that you might want to add that to your public awareness campaign in some kind of formal way. Thank you very much.

DR. BIRKHEAD: Thank you.

ASSEMBLYWOMAN GLICK: Just one last question. The last time we saw each other I think we were around a table discussing the expansion of the scope of

practice for pharmacists to be able to vaccinate.

DR. BIRKHEAD: Yes.

ASSEMBLYWOMAN GLICK: I'm wondering whether there are any early responses from the pharmacy community as to whether they are seeing large numbers of people and where are they in the pecking order of receiving doses to be available to the public in general, and how do you control the priority list as opposed to somebody just coming in and saying, hey, I want that and they're not within that

priority list? How does that --

DR. BIRKHEAD: Pharmacies are an important part of our strategy to get H1N1 vaccine and indeed seasonal vaccination out there, and the legislation I think has been helpful to allow vaccinations to be given in more pharmacy settings.

We've made an effort with H1N1 to reach out to the main pharmacy chains as well as the independent pharmacies through the Pharmacy Association and through the

Board of Pharmacy to get them to sign up.

As I mentioned, we have a registration process for providers that want to get give vaccines, and many of the large chains and smaller pharmacies have indeed signed up.

Every provider that gets a vaccine will sign a federal provider agreement which commits them to follow the priority groups, so I think we'll leave it at that in terms of how that piece of it gets enforced.

We do plan to distribute vaccines to pharmacies, at the same time that we distribute it to the broader community.

Again, our strategy is to get vaccines out in as many different venues and settings as possible. The one thing we will avoid, however, is to giving it to the pharmacies before the physicians and their offices get it, which is a common complaint from physicians each year.

So we will try to do it in a fair and equitable fashion and get the vaccine

out as widely as we can.

CHAIRMAN GOTTFRIED: One question prompted by something that Mr. Lancman asked.

In the nursing home setting where you have a statute, having mandatory offering with a right to refuse, does a nursing home employee -- well, what is the process for a nursing home employee to refuse?

Can they simply not get the vaccine?

Do they have to sign a piece of paper saying I refuse?

Do they have to give an explanation?

DR. BIRKHEAD: I don't believe that the legislation spells out any

requirement for a signature or anything, an explanation, no.

CHAIRMAN GOTTFRIED: Okay. And, again, in your testimony you said the take-up rate for vaccination among nursing home employees on a voluntary basis is about

what?

DR. BIRKHEAD: On average, about 30 to 40 percent.

CHAIRMAN GOTTFRIED: Like a third or less than a half of what you would hope for?

DR. BIRKHEAD: Correct.

CHAIRMAN GOTTFRIED: Thank you. Other questions?

(No verbal response.)

Thank you very much.

DR. BIRKHEAD: Thank you.

CHAIRMAN GOTTFRIED: There are 150 members of the public that get to ask these questions. Three of them are here.

Our next witnesses coming up together are Isaac Weisfuse, Deputy Commissioner of the New York City Department of Health and Mental Health; Kathleen Grimm, Deputy Chancellor; and Roger Platt,

Executive Director of School Health from the
New York City Department of Ed.
(The witness was sworn.)
DR. WEISFUSE: Good morning,

Chairpersons Gottfried, Nolan, Glick, and Lancman. My name is Dr. Isaac Weisfuse. I'm the with the New York City Department of Health and Mental Hygiene. I'm joined here today by Kathleen Grimm, Deputy Chancellor at the New York City Department of Education; and Roger Platt, Executive Director of School Health also from the New York City Department of Ed and the New York City Health Department.

On behalf of Commissioner Farley and Chancellor Klein, thank you for the opportunity to comment on the City's work to protect the citizens of New York against H1N1 influenza.

We have submitted a brief testimony and a copy of a PowerPoint presentation submitted for the record and, in the interest of time, what I would like to do is really hit the highlights of those documents.

As you heard in the prior testimony, we estimate that during the

spring, between 750,000 and one million

residents of New York City became ill with an influenza-like illness. Most, thankfully, recovered. The average time of illness was about four to five days, and we did demonstrate high rates of illness and rapid spread in children.

As opposed to seasonal influenza, we actually had lower rates in the elderly populations in the city. And, as you heard, there are certain risk groups who had worse outcomes than others that were gone through in the prior testimony.

Looking forward to this fall and this winter, we believe that both H1N1 and seasonal influenza viruses may very likely circulate in the city. We know from past experience both in New York City and the United States and in the southern hemisphere, that H1N1 is not likely to cause high rate of severe illness and the virus itself has been looked at from many different places across the world, and there has been minimal shift or change in the structure of the virus which is a good

thing, because changes in structure may also accompany changes in severity.

And since it is mild, we wondered if it is around, we want to be less severe and, therefore, a stable structure.

We don't know when, you know, New York City has been fairly quiet thus far in terms of H1N1. There are some cases in the city, but has not caused the explosive outbreaks that we saw in the spring.

Our surveillance approach this year is to look for citywide patterns of illness and look at severity as it may occur in the city. To do that, we get information from 90 percent of hospital emergency departments on a daily basis in New York City, and we look at why people are going into the empty department, and we look at people who are saying that they have an influenza like illness, and then look at that on a daily basis and compare it to prior days, prior months, and prior flu seasons.

Thus far, the surveillance data

has been fairly quiet. Just as we did this past spring, we are going to do monthly telephone surveys of New York City residents to look at influenza-like illness in the community, and then find out how much influenza there may be circulating in the city.

And then we're going to be looking intensely with a number of hospitals looking at why people are going to those hospitals and what the severity of illness is.

As you heard before, vaccination is really the gold standard in terms of prevention of influenza, however, there are other approaches that can be used including handwashing, anti-viral drugs, isolation or separation of ill from non-ill, and, as was discussed in the last section, personal protective equip.

You also heard that there are two separate vaccines coming or here. One is the regular seasonal influenza vaccine and the other is the H1N1 vaccine. We are

planning in New York City to make both of

those vaccines available in a number of places, to give people choices in terms of where they may get vaccinated.

So we're working with doctors offices, we are going to be giving vaccines to 60 hospitals and they will then distribute to their staff and their inpatients and also their outpatient clinics.

With community health centers, we have a few immunization clinics that will get H1N1 vaccine. It was mentioned at the end of the last testimony, we are working with some large pharmacy chains in the city to provide them with vaccination and, indeed, some of them are already providing vaccination against seasonal flu vaccine.

You may hear about from my colleagues a little bit more about the effort to provide H1N1 vaccine in schools in New York City, so I will not comment on that.

Another issue that was paid a lot

of attention to since the spring has been the situation with hospitals in the city. We know that in May and June, hospitals in the city and definitely in the borough of

Queens were really overwhelmed with the number of patients who were coming for a variety of reasons to the emergency departments.

We are working with a hospital system in the city to try to mitigate that issue. The reason why it's an important one to address is to the degree that the emergency departments are overwhelmed, the degree that care for everyone may suffer as a result.

So we want to make sure that appropriate people are going to emergency departments.

So we are getting out some messages to the community about this issue trying to tell them that if they have mild symptoms, they don't need to go to the emergency department. They may seek some help from their primary-care physician or

other health care personnel, and we are going to be putting that information in a health bulletin which has already come out.

We are also purchasing advertising space on subways and other transportation hubs and also producing radio

spots. These haven't gone out yet because we've like to hold them for the time when they're going to be most valuable.

All these issues cost money, and we want to do it at the time that's really going to help people make their decisions. We right now have a very quiet situation in New York City, so we are holding off until it's a better time.

We also have produced a website, www.NYC.gov back slash flu, and giving all our flu information onto that website and we've helped and worked with 311 very closely to help them provide information to the public as well.

In the background, we're also working on something we call a medical call center that we'll be able to provide advice

to people who call in concerned about illness either in themselves or in their families, or other loved ones, that we are willing to open, again, when the time is right when we see that flu is in New York City.

In terms of the medical part of the equation, we've been working with hospitals and talking to them about the need

to, perhaps, if their emergency departments become very crowded, to open alternative care sites within their campuses, and they have been very very good at following up on that. Assembly Member Lancman and I were out at Queens Hospital just about two weeks ago in a discussion with the staff there. They are pretty ready in terms of directing people away from emergency departments and into outpatient centers and dealing with that.

HHC has also promised to create fast track flu shot centers and, so, in all these ways, we're trying to give people appropriate levels of advice and care, but

realizing that we don't want emergency departments to become unnecessarily crowded.

We're also dealing with employment settings in a number of ways. We, first of all, we've had conversations with hundreds of companies over the past three or four years during our regular pandemic flu influenza preparation, and we're holding two forums for preparing for influenza in the workplace in late October and early November that all companies in the

city, both big and small companies can sign up for and hear the latest news about some issues around how we've prepared for the influenza season, some basics about H1N1 transmission, issues around vaccination, and then influenza health and safety for the workplace, and, finally, business continuity.

These are issues that we worked on with our office of emergency management for several years now, but we think the time is right to repeat this message to businesses that may not have been taking

this to heart during prior years.

I now want to turn to my colleagues on my left and right to talk about school issues in New York City.

MS. GRIMM: Thank you. I'm going to first talk about the fact that this year our approach is going to be somewhat different, in that we do not plan on closing schools. In the spring, there were roughly 60 schools that were closed.

The reason for our change in approach this year is based on the fact that first of all, we know a lot more about the H1N1 influenza. It does not appear to be

severe, any more severe than regular seasonal flu. We have many more preventative measures in place right from the first day that school opened, and, of course, the major thing is we have a vaccine available.

And, we also think that many of our children who had flu last spring are now immune. What we're going to emphasize this year are the preventative measures. Washing

and sanitizing hands as often as possible, avoiding touching mouths and nose. Cover the coughs and sneezes. Our bathrooms are stocked with soap and towels. We are exploring the placement of hand sanitizers in our schools, although I can tell you most of our schools already have them. Parents are being instructed that if their children are sick to please keep those children at home and to keep the child at home until at least 24 hours has passed since the last flu symptom, and, of course, what's really major is that we will be offering the H1N1 vaccination to our children with parental or guardian consent.

We, in fact, during the first

week of school backpacked a letter home to parents. We have been providing informational materials to schools. All of our schools have posters that are put up in terms of frequent washing of hands, covering of coughs.

We are doing outreach to elected officials, to our community education

councils, to our parent groups. We are sending weekly updates to all of our principals in terms of what's going on, and, of course, we have ongoing communication with our school nurses.

The vaccination plan is to provide the H1N1 vaccines to school-aged children. It's both our public and our non-public schools that are participating.

Now, the plan right now is that we believe we will have sufficient supply of the vaccine by the last week in October, and that is when we plan to begin vaccinating children in our smaller elementary schools.

There will then be a rollout to our larger elementary schools where we will have teams that go in to assist the school nurse because there are too many children for just the school nurse to handle. And

then we will also, for five weekends in November and December, have what we call PODS, where we will be actually distributing vaccine to middle school-aged children and high school aged children. They will be

centrally located. There will be different locations in each borough so that parents have some choice in terms of going.

I can only emphasize that this program is totally voluntary. As I say, we will have a written consent that parents or guardians have to sign. And it's also a supplementary way to provide the vaccine in addition to all of the other opportunities that are out there. Parents can go to their own pediatrician. They can go to their own health clinic. There are many ways that children can get this vaccination. I would like to ask Dr. Platt if he would talk about exactly the measure we're taking as we see cases of influenza in our schools.

DR. PLATT: We've created a robust system for recording the presence of influenza-like illness in the schools. Nurses who have access to our electronic record report on a daily basis through that

record, so we know at the end of the day, at the latest the next day, whether there have been students with influenza-like illness in

the school.

In addition, we've set up a separate tracker system so that in schools that don't have access to our electronic record, predominantly our non-public schools, they can also report easily and quickly on a daily basis whether or not there are students with influenza-like illness in the school.

The good news at the moment is that the level of influenza-like illness in the school is very low. We have defined as a reason to explore more thoroughly what's going on in a school the presence of five or more students with influenza-like illness in the school. We haven't had a single school in the first five weeks of school that has reported more than five cases of influenza-like illness.

If we do get schools that develop more influenza-like illness, we will intensify our efforts to make sure that the staff and the students in those schools are following the recommended methods for

minimizing the acquisition and the transition -- transmission of flu as previously described.

If there is a very high level of influenza-like illness in the school defined as four percent or higher students on a single day with ILI, then there will be a thorough on-site assessment, a review with the commissioner and a decision possibly, although we think even in that case it is unlikely, to close the school.

We believe we have enough measures in place not to close a school, and the only reason to close a school would be to protect vulnerable children in school, particularly in schools that have sizable numbers of such children.

So that's where we are. We did conduct last week a pilot to assess our ability to vaccinate a school settings. We offered seasonal flu vaccines since H1N1 was not yet available. In six of our schools, five public and one non-public school, that pilot went very well, gave us a very good

sense of the rate at which our nurses could immunize, and we were able to complete all of the immunizations to which parents had provided a consent for.

CHAIRMAN GOTTFRIED: I have a few questions.

First, it's for the City Health Department. I'm very concerned about the lack of a really massive public education program around preventive measures.

I ride the subway every day. There are -- the MTA has posters up all the time about staying back from the edge of the platform, not running. I don't know how many people die every year from running on subway platforms, but it's got to be a lot less than the roughly 2,300 New Yorkers who die every year from the flu.

The New York City DOT has signs up on every corner with blinking lights telling us when to walk and not to walk. And have for I don't know, hundred years.

It seems to me there's a lot more that New York can and should be doing to be

drumming into people's minds the notion of frequent hand washing. And not just this season, but it should be something that we all grew up with, let alone starting to see tomorrow morning.

DR. WEISFUSE: If it's okay, I'll respond. It's what your mother taught you to do when you were two or three years old and it's a very important message.

We also know that, unfortunately, adults tend to neglect that message. And we have put out information for years through posters, websites, et cetera, on the importance of hygiene in controlling not only flu, but other respiratory or other infectious diseases. It's really a cornerstone of prevention of disease any place.

It's been -- because it's a message that isn't very sexy, if you will, it doesn't involve, you know, fancy procedures or, you know, new age technology, it's one that you tend to say a lot and people just sort of think, well, it's, you

know, again, if it's something I learned in childhood, it may not be as important.

We do have -- we've been working with the MTA and Transit Authority on subway ad campaigns. We have it and it's been designed. It's fairly ready to roll out in the next couple of weeks.

We're cognizant of the fact of how to get some of these messages across and how to get them to stick and change people's behavior has really be a struggle with this issue.

We feel that we've been out there in the past on this issue, but we need to get people's attention at the time that things start. I think that the teachable moment, if you will, is at the time that we have an issue in the city and that time may be coming soon and we're prepared to give the subway posters and other messages all over the place on hand hygiene.

We've also, as Deputy Commissioner Grimm talked about, put all the posters in all the schools and they're

available through 311 or our website so people can get them and hang them up.

But in terms of city advertising, we are about to launch into that.

CHAIRMAN GOTTFRIED: I agree,

it's a difficult message to get across. It's not clear whether drumming it in or waiting or whatever is the methodology for getting that in, getting that done and also changing behavior is an important question.

DR. WEISFUSE: My own suggestion would be if you had posters with photo micrographs of what the dust mites that live under our fingernails look like, you would breed paranoia and a level of handwashing to leave the water supply people to be concerned, but that's just my suggestion. What do I know?

ASSEMBLYWOMAN NOLAN: In the testimony, we talked about it and perhaps three quarters of a million to a million New Yorkers affected in some way by influenza-like symptoms, how many of them were children? 60 schools closed, that

would be about 60,000 kids at least, but --

DR. WEISFUSE: I think when we -- if I recall correctly, the rate of ILI illness at least in the first survey was among school-aged children was probably in the 20 percent range, roughly. So of those a million --

ASSEMBLYWOMAN NOLAN: A million people, 20 percent were --

DR. WEISFUSE: Of those who replied -- when we called, we asked not only about the person who answered, but what was going on with their family. And then we asked for ages of people in the family and it seemed to me, as I recall the data, it was about 20 or so percent.

ASSEMBLYWOMAN NOLAN: Is that a higher percentage than you would have expected in the kind of studies that -- your colleague who spoke first talked about, the State Health Department, is that a higher percentage?

DR. WEISFUSE: Well, you know, H1N1 is a novel virus. We know that from

experience in New York City and elsewhere around the world that it was transmitted rapidly in some congregate settings including schools. So it's not surprising that we had a pretty high percentage.

ASSEMBLYWOMAN NOLAN: I'm also happy to hear, is it Dr. Platt, on the list because I've checked it and when you said anybody with five or more, I thought I was remiss, I said, gee, I didn't see any. But

there haven't actually been any at this point.

What does your unit do a little bit, maybe you can share with us, I wasn't familiar with it, that the city has an office of school health at this level, and how do you do things like determine whether there are really like soap and towels and things like that in school bathrooms, because that sounds great from Tweed but reality is a different thing.

I sent my son in with about 12 Scott towels, because the teacher supply list grows every year, and I mean it's

almost a comedy how much that we're asked to give in as parents to our children's schools, and yet, that's still always the perennial complaint.

MS. GRIMM: I know that it's a complaint, assemblywoman, but all our schools tend to ask parents --

ASSEMBLYWOMAN NOLAN: And that's fine with me -- I'm not necessarily complaining, I'm just wondering, does a unit like your yours have some operational responsibility, for example, to send a team

out to check to see if there is indeed soap and water at these places?

DR. PLATT: We do not do routine surveys.

ASSEMBLYWOMAN NOLAN: So it's based then on the principal?

DR. PLATT: We do have nurses and other staff in schools, and if we find a situation where a bathroom is not supplied, we certainly bring that to the attention of the principal.

ASSEMBLYWOMAN NOLAN: Who is the

person who does that?

MS. GRIMM: Certainly it's the custodian's responsibility to see if they are stocked. And our deputy director of school facilities are in our schools every day and that's part of what they do in terms of --

ASSEMBLYWOMAN NOLAN: Since this happened though, has there been any attempt to organize sort of -- I'll call it a SWAT team for Scott Towels, but has there been any effort to step it up?

MS. GRIMM: Yes.

ASSEMBLYWOMAN NOLAN: Because we have to recognize the reality, the reality

is most schools in my district, you could walk into a bathroom there would be nothing.

MS. GRIMM: I would appreciate knowing that school.

ASSEMBLYWOMAN NOLAN: But the truth is, Kathleen, that's the kind of thing that parents call constantly about.

Have you done any extra stepping up to target that issue?

MS. GRIMM: Yes. We have talked to our school facilities people and we have said how important this is as a citywide initiative, and that they are responsible for making sure that those bathrooms are stocked.

ASSEMBLYWOMAN NOLAN: If you go to a website like Inside Schools.com, that's a parental -- parents write in constantly about that, do you use vehicles like that to determine when you say you want to know about it, does somebody say, look, all these parents wrote in about this middle school, we're going to send someone?

MS. GRIMM: It's usually brought to our attention and we certainly follow up on it.

ASSEMBLYWOMAN NOLAN: Is there any kind of a goal of a certain number of inspections that DOE says we're going to look at a certain number of schools this month and see if they're doing things like having soap and water at the school? Is there a target like, okay, we're going to

look at 50 schools, or --

MS. GRIMM: Well, I don't know exactly what those targets are, but certainly every deputy director has a target that he has to meet or she has to meet.

ASSEMBLYWOMAN NOLAN: 60 schools were closed, some only a day or two, was any school closed longer than five days?

MS. GRIMM: I think there were perhaps one school and, of course, there was a holiday involved and it might have been closed for six days.

ASSEMBLYWOMAN NOLAN: And then after-school programs, many of our schools use after-school programs, that's also a parental concern, that's the end of the day, that's when the school bathroom is often not useable. Has there been any effort to work with after-school programs to make sure that they're stocked with the right supplies?

MS. GRIMM: The bathrooms should remain stocked throughout the day including the after-school programs.

ASSEMBLYWOMAN NOLAN: You know,

that's another thing that certainly would be a parennial issue.

MS. GRIMM: Can I just go back to something you raised just to make sure everybody understands it?

ASSEMBLYWOMAN NOLAN: Sure.

MS. GRIMM: The office of school health is actually a very unique organization created by this mayor.

Dr. Platt reports jointly to the chancellor and to the Commissioner of Health and what we have found is that it is a terrific vehicle for us to work very closely together, especially in times of situations like the H1N1 flu, and it's really I think a model for the country.

ASSEMBLYWOMAN NOLAN: And then of all our schools, we have like a thousand elementary schools, a hundred high schools, and say four or 500 alternative, small, charter, mini high schools.

Do every one of them have a

school nurse?

DR. PLATT: Let me first say, we

staff by building, obviously, not by school. As you know, a lot of buildings now have multiple schools in them.

Of all of the Department of Education buildings, there is a school nurse in roughly 85 percent of them. In an additional 10 percent, there's a school based health center. So there are only five percent, five-six percent of our sites that have neither a school nurse, nor school based health center.

ASSEMBLYWOMAN NOLAN: Is there any particular type of school that doesn't have a nurse, is it a big school, small school, high school, middle school, I mean, just a random assortment?

DR. PLATT: Well, it's not random. But it's based on the mandates that the two departments face. The Health Department is mandated to provide a nurse to every elementary school with over 200 students, and so virtually all elementary schools have a nurse.

The Department of Education is

mandated to provide a nurse whenever there is an IEP or Section 504 nursing requirement.

The bulk of the schools that don't have a nurse are the smaller high school campuses because there are relatively few mandates at that level.

ASSEMBLYWOMAN NOLAN: Do all the charter schools have school nurses, do all the parochial schools? I know there was that was a council initiative.

DR. PLATT: Right. With respect to the charter schools, a high percentage of the charter schools are in buildings that are actually operated by the Department of Education. And so since --

ASSEMBLYWOMAN NOLAN: Access the other schools.

DR. PLATT: So there is a nurse for the building. There are some small charter schools in their own buildings with less than 200 students that do not have a nurse.

In the non-public schools, all

schools that have elementary students and over 200 students may request a nurse, and if they have a medical room that's appropriate for the nurse to use, we will assign a nurse.

But there are many many small non-public schools and also a sizable number that don't have an appropriate facility for a nurse, so that we have about 250 non-public school nurses.

ASSEMBLYWOMAN NOLAN: And then the 85 percent, there's not a vacancy, in other words, you can't fill these jobs, it's just some schools don't meet the qualifications.

I mean, is there a job that you have trouble recruiting people for?

In other words, when you said85 percent and then you've explained it and I appreciate that, some of the criteria, are there vacancies because there are vacancies or just some schools don't meet these various listings, and therefore --

DR. PLATT: Some schools just

don't meet the various criteria. Of the

schools that do have a nurse, about 90 percent have a staff nurse employed either by the Health Department or the Department of Education, and about 10 percent have a contract agency nurse.

ASSEMBLYWOMAN NOLAN: I would certainly want to recommend that the department look at having some kind of a spot check maybe through your office to make sure that the compliance with soap and water and paper towels is happening because we hear it all the time.

You know, I want to be fair, I mean sometimes things -- it's a moment in time, a parent complains, maybe it's corrected. It's a hard thing to get a handle on, but I do think there has to be something other than just, you know -- so much is centralized in this administration, and yet something like that is relying on the network of good will in the sense of the custodians and the school principals, some of whom may not want to report to central

that they can't get the supply right.

So you have make sure that people don't feel that they get in trouble if they

say there's no Scott towels. You have to be able to have that.

Do you provide that? Is that a different division, Office of School Facilities provides that?

MS. GRIMM: It reports to me.

ASSEMBLYWOMAN NOLAN: Are they actively making sure that those supplies are there?

MS. GRIMM: Yes, but we'll certainly take another look, and I will impress on people how important this is.

ASSEMBLYWOMAN NOLAN: And for the six schools that were in the pilot, what was the rate of consent among parents?

DR. PLATT: About 30 percent.

ASSEMBLYWOMAN NOLAN: Only 30 percent? You offered it to those people and it was only about 30 percent.

Do you anticipate that lower level when you expand this now?

MS. GRIMM: We're operating on the assumption that we will get 50 percent. I mean, that's what --

ASSEMBLYWOMAN NOLAN: If the pilot only got 30, I'm assuming those people got extra attention. It was all done

perfectly --

DR. PLATT: Well, the pilot concluded on Friday. So you're getting brand new information, and there's no question that we will think about that in terms of the planning for the larger effort.

As we sit here today, the plan is to be prepared to immunize up to 50 percent of students in any given school.

There is some reason to believe that the percentage of parents who consent for in-school immunization will be lower than that, but we want to be prepared to offer immunization to all those who want it.

ASSEMBLYWOMAN NOLAN: And in the K to eight versus junior high school. I see that you have middle school children being offered it on the weekend, but, of course,

some schools are K to eight. So those six, seven, and eighth graders get the immunization, but if you're in a middle school you don't?

I would almost suggest you ought to do K through eight even if that means going into the middle schools, but --

DR. PLATT: I think this is a

pretty complex set of issues because of the complexity of the school system. The current plan is that we will immunize by school. So if a school has elementary grades, we will immunize that entire school.

ASSEMBLYWOMAN NOLAN: So an intermediate school that has a five, six, seven, eight should be included in this?

DR. PLATT: No, we define -- for this purpose, we define elementary as third great or lower.

So we do not plan to immunize five through eight schools.

MS. GRIMM: But if a school is K through eight --

ASSEMBLYWOMAN NOLAN: Then if

you're an eighth grader in some school, you get it. And if you're a fifth grader in another school, you don't?

MS. GRIMM: You get it anyway, but the question is do you get it on site or not.

ASSEMBLYWOMAN NOLAN: Right, but it's being driven by the type of building, not the type of child, but you don't feel you're shortchanging some, or overdoing it with others?

DR. PLATT: We are trying to achieve the best balance between immunizing as many as children as possible, and recognizing the reality of the workforce that we have.

ASSEMBLYWOMAN NOLAN: And then the 60 schools that were closed, are you going to offer it to all of them regardless?

DR. PLATT: Yes.

ASSEMBLYWOMAN NOLAN: It seems to me that --

DR. PLATT: If there is an elementary school, this is most common in a

non-public elementary school that does not have a nurse. In those schools, an agency nurse will be assigned to go into that school and immunize on site.

ASSEMBLYWOMAN NOLAN: What about the schools that were closed? The 60 schools that closed last spring have a high degree of parent anxiety.

DR. PLATT: They will be treated no differently than any other school which means that, since most of those were elementary schools, those students will be immunized on site.

ASSEMBLYWOMAN NOLAN: Well, that might be something you want might want to look at because those parents were very very anxious, so you might want to -- you might want to make some exemption and say, well, those 60 schools, we're going to offer it everyone because there was such a high degree of -- see, this is about being parent fueled.

I understand where you're coming from in terms of the logistics, but if your

child was in one of those schools that were closed last year, you would like to feel with the immunizations were on site and available right away at a higher priority, I think.

DR. PLATT: Well, we will certainly take that into account. Keep in mind that we view this as a residual system.

We are saying to our parents, the first option for you is to go to your own doctor and get immunized. And I think there are good reasons to make that the first option. So, you know, we'll certainly take your comments into account.

ASSEMBLYWOMAN NOLAN: Thank you.

CHAIRMAN GOTTFRIED: Any

questions?

ASSEMBLYWOMAN GLICK: You indicated that your surveillance will include monthly phone surveys to gauge illness that's sort of not necessarily apparent.

There are a substantial number of people who don't have phones. Does that

mean that people who tend to be in poorer communities who opt not to have phones or opt not to have a phone, they can't afford to have a phone, so there is some group of people who will be less likely to be part of the survey, and how do you account for that in the way you handle your epidemiological survey of what's happening?

DR. WEISFUSE: That's a problem with all telephone surveys, that people who don't have phones, or don't have a phone listed or whatever, and that certainly would be true in this survey.

The purpose of this survey is to look at influenzae-like illness over time. Is it rising? Is it increasing? And it gives us kind of a rough snapshot rather than a specific picture, and by doing it

every month, and we just did the October which will be ready in a few weeks, by doing it every month, we'll be able to look at that.

There are certainly flaws in any telephone survey that would suggest that

it's not a complete 100 percent snapshot of the city, but we think it's a relatively doable survey that would give us some sense of what's going on in the city.

So you're right, it doesn't include the people without telephones, but by looking at it over time and using the same methodology, we think we'll get out of it. It's not meant for us to case count because, even influenza-like illness as a subject is not necessarily due to influenza. There are other bugs that may cause that.

ASSEMBLYWOMAN GLICK: You mentioned that the City Health Department is working with some pharmacy chains. The State Health Department was indicating, and maybe this is true in different parts of the state, that they are also trying to reach out to independents.

I guess I'm wondering whether or not the City Health Department is focusing

only on larger chains which tend to make it easier for you to deal with or is there some ability to work with independents which tend

to be smaller business and unfortunately my experience is that smaller businesses kind of get short tripped.

So I'm just wondering how that's being balanced, especially since some of the smaller pharmacies are trying to compete by providing extra service.

DR. WEISFUSE: I think it's a good point. Our initial design, if you will, was to try to get very quickly, very broad coverage. And so the chain pharmacies do offer that as a possibility, and we've gotten very good cooperation from the chain pharmacies. We have not admittedly delved as far as we've done with the chain pharmacies to the independent pharmacies for some of the logistical reasons that you've mentioned, although we are certainly willing to work with them and that would be the next step.

ASSEMBLYWOMAN GLICK: Maybe you can work with small business services because it's been my experience that in my

community, and I hear from my colleagues,

that small businesses have not gotten attention in general for the last several years and this would be one area where maybe there could be some bridge built.

Thank you.

ASSEMBLYMAN LANCMAN: Good afternoon. My office attended the briefing that the Department of Education had, I believe it was in the beginning of September when the DOE announced its plan for how H1N1 was going to be addressed in the schools and, from the feedback that I got, it was a very thorough and comprehensive plan.

But there are just a couple of issues I'd like to go over. First, to follow up on Assembly Woman Nolan's line of questioning regarding the school nurses.

In buildings that don't have a school nurse or another health professional, who does the responsibility for that front-line interaction with students who might be sick fall on?

Is it just the teachers?

DR. PLATT: In most of those

schools, but I can't say all, there is a designated health aid, there's a title of health aid in the Department of Education. And that health aid mans a room that contains student health records and will generally provide minor first aid to students who need it.

It is likely that that is the person that the principal will assign to deal with the issue of influenza-like illness in children, but that -- the decision of who in a school site will be asked to deal with influenza-like illness in children rests -- when there's no nurse or nurse school based health center, rests with the principal.

ASSEMBLYMAN LANCMAN: That's a little troublesome to me because teachers are wonderful people, but they're not healthcare professionals, and to put them in the situation where they've got to assume the responsibility of a nurse or a healthcare aid without that kind of training or, frankly, without signing up for that gig

seems to be a little unfair.

Is there any way that you could look at maybe ensuring that every school has at least -- what was this other category? A school health aid of personnel, and if you could get back to me on the number of schools that are lacking any kind of health care professional, whether it's a nurse, or this health aid, or what have you, and what kind of guidance you're giving to principals when the student presents influenza-like illness.

You know, it's been talked about kind of anecdotally that the school health professionals are really the ones in the front line and they're the ones especially in the spring when this all kind of materialized out of the blue almost, so it would be especially concerning to me that there are schools that don't have any kind of healthcare professional at all, and in those cases that there's no specific guidance to principals about how they should respond and react.

DR. PLATT: We will certainly respond to you. I will say this, there is a

nursing supervisor assigned to every public school site, so there is always somebody that the principal can call if the principal has questions about how to deal with a particular health issue. So that option is available.

ASSEMBLYMAN LANCMAN: Well, if you could get back to me on that information, because I would be very concerned if teachers are going to be deputized in these schools to act like healthcare professionals and it raises a lot issues for them and for the kids.

In that vein, I'm just curious for the schools that are the elementary schools where the vaccine is going to be made available to students whose parents want them to get vaccinated, will the teachers in those schools also have the opportunity to get vaccinated there or are they on their own?

MS. GRIMM: We're encouraging,

of course, our teachers and all of our school staff to speak to their own healthcare providers. We will not be providing vaccinations to anyone except to

children in the schools.

ASSEMBLYMAN LANCMAN: Let me ask you about the distribution of the vaccine to private schools.

I have a number of private parochial schools in my district. I assume the criteria is going to be the same. You're going to start with smaller elementary schools, K through three, and then expand from there, or is it a different program for the parochial schools?

DR. PLATT: The initial start will be only in the small public elementary schools, that is the October 28th start date. The non-public schools will start at the same time. We start with our larger public schools which will be the following week.

The schools where we have a school nurse, the immunization will be done

by the school nurse. In other schools we will bring in a contract nurse to provide those immunizations and that contract nurse will be assigned to be in that school as many days as is necessary to provide all of the immunizations for which we have consents.

So the priority private schools will start the second week but the vaccinations will be at the private schools themselves, you know, as long as they meet that --

ASSEMBLYMAN LANCMAN: Same elementary school --

DR. PLATT: That is correct.

ASSEMBLYMAN LANCMAN: Just to clarify, most of these private schools in my district are K through eight. So as long as they've got K through eight, at least K through three, they're going to be on that list?

DR. PLATT: That is correct. There will be on-site immunization and in a K through eight school, all students will be

offered on-site immunization.

ASSEMBLYMAN LANCMAN: Okay. And for Weisfuse, you're the closest thing that I've got to a general New York City representative.

Are you able to answer a question about HHC and it's -- the extent to which it is vaccinating it's employees and the scope?

DR. WEISFUSE: I really can't

comment on their policy. I heard what you had asked at the prior session, and I don't think that I can really comment on how they're doing it.

ASSEMBLYMAN LANCMAN: In terms of -- I heard it was you or somebody mentioned the MTA before, maybe it was just in the back and forth with Assemblyman Gottfried, but to my knowledge, and the MTA is not represented here today unfortunately, but to my knowledge, the MTA, unlike the New York City Department of Education, has not yet come out with a, here's how we're going to deal with the H1N1 situation in our agency.

Is that something that the city

Department of Health monitors, the different agencies or authorities that operate within New York City to make sure that they've all got some kind of H1N1 prevention plan?

DR. WEISFUSE: You know, I don't know where MTA specifically falls in the regulatory issue. Over the past we've met with MTA to discuss flu preparations, so their staff is aware of that, but I don't know if we have that kind of authority over MTA.

ASSEMBLYMAN LANCMAN: If you're

not clear who has authority over the MTA, you're not alone.

Thank you very much.

CHAIRMAN GOTTFRIED: Thank you very much.

Our next witness is Jean Stevens from the New York State Education Department.

(The witness was sworn.)

MS. STEVENS: Good afternoon, Assembly Members Gottfried, Nolan, Glick, and Lancman.

My name is`Jean Stevens. I'm the Associate Commissioner for Instructional Support and Development Office for the New York State Education Department.

Thank you for permitting us to provide testimony on H1 education, outreach and prevention, and how schools are implementing these steps. H1N1 influenza has impacted all program offices in the State Education Department.

My testimony will highlight key education and outreach actions that have taken place across the agency to address H1N1.

The New York State Department of Health and the State Education Department have worked collaboratively since April of this year to ensure that teachers, students and parents, and school administrators are kept informed and provided with up-to-date guidance to effectively address H1N1.

A significant component of this partnership has been SED's active participation on the Department of Health's

H1N1 work groups dealing with vaccination and community mitigation, including their subgroups for school guidance and school surveillance. This strong partnership has been exceptionally valuable as we continue to respond to this evolving situation.

Just as we are working as partners on the state level, the education department and the Department of Health have strongly encouraged local school administrators to partner with their local county Department of Health and their school medical director as they address H1N1 influenza together at the local level.

Since H1N1 emerged in April of 2009, SED and DOH have jointly issued six guidance documents directed to institutions

of higher education, public, non-public and charter schools, school based health clinics, and other educators and local Health Department officials.

The guidance documents offered critical recommendations and resources, including talking points for school

officials, sample letters for schools to send to parents, sample press releases, instructions for the potential closing of schools when so indicated, and suggestions for reducing the spread of H1N1.

Instructions for completing the Department of Health's voluntary survey on school absenteeism and dismissal and recommendations for non-pharmaceutical community-based measures to reduce the likelihood of disease transmission in our schools and colleges.

The sample letters and talking points are included on the websites for Center for Disease Control, Department of Health and the New York Statewide School Health Services Center as well as a 24 hour toll-free hotline for questions.

Our joint guidance documents are

available on the SED H1N1 website and that's www.nysed.gov. In addition, SED also disseminated guidance to school food service managers describing how to continue to provide reimbursable U.S. Department of

Agriculture meals to low-income children during potential school closures related to H1N1.

Planning for the immunization of large numbers of students poses many challenges, including coordination between schools, parents, local departments of health and school medical directors.

Local health departments in consultation with school administrators and medical directors will determine the best plan for action for their own community, including whether or not to establish a school-based H1N1 vaccination clinic.

Last November, Ed lost 6802, Chapter 563 of the Laws of 2008 was amended. The Board of Regents then created regulations that authorized pharmacists to give vaccinations to adults 18 years of age or older as long as they have completed additional training and are certified to do so by the State Education Department.

This has the potential to make vaccinations much more accessible to many

adults. To date, approximately 1,300 pharmacists have been trained and have been certified. The turnaround time for processing of that certification is 48 hours.

The Office of Professions web page has detailed information on how pharmacists become certified to give these vaccinations.

Our public libraries play a critical role in disseminating a variety of information to their communities. Library websites that feature priority linked H1N1 information, handouts to pick up at the library, library programming, and reference services all assist individuals and community agencies to make informed decisions during the flu season.

The state library has developed an H1N1 web page, as well as a communications tool kit for public libraries in New York State.

To further expand our outreach activity, staff from our agency and the

Department of Health and the New York State Emergency Management Office joined Governor Paterson in a series of town hall meetings across the state between August 31st and September 8th to discuss the State's H1N1 planning efforts.

The Education Department's H1N1 website provides up-to-date information and resources both to school communities and the public. This includes items ranging from official guidance documents to videos in American sign language demonstrating the most effective way to wash hands.

We have also addressed H1N1 for our own employees. A draft has been developed based on guidance from the Center for Disease Control, Department of Health, and the Governor's office for employee relations.

The Education Department has been preparing for a potential pandemic since 2006 as part of a comprehensive continuity of operations planning. This has included the identification of emergency lines of

succession for senior staff and mission critical functions that we need to continue in an emergency such as a pandemic.

We are also planning to launch our N.Y. alert which will enable us to provide staff and educational institutions with critical information during an emergency.

In conclusion, we continue to work very closely with our partners, the State Department of Health to provide the latest H1N1 guidance to the entire education community.

I appreciate your attention and I would be happy to answer any questions that you might have.

CHAIRMAN GOTTFRIED: My main question which I've asked others as well is about what I see as a real lack of a massive education campaign to promote the hand washing and other good hygiene practices, the modern way for coughing, et cetera, et cetera.

Why is there not a major effort

to make sure that posters and classroom discussions and what not go on in every school in the state?

CHAIRMAN GOTTFRIED: Actually, assemblyman, we've done a number of things to promote that and push it out to address some of your concerns. Not only do we have a website and we all know that everyone doesn't wake up every morning to look at websites, the information has to be pushed out more aggressively.

We've worked with a lot of our organizations particularly with our district superintendents, our BOCES superintendents who meet with all of their superintendents, and often the other big four superintendents outside of New York City on a monthly basis.

We have also, in the information on our website, there are a number of downloadable pieces of information that we've shared all of the Department of Health, the Education Department, CDC. We've really tried to link that.

I will say here in New York City,

there's some very very good materials that are fact sheets that are put out in eight different languages so we've done that.

We've aggressively tried to push out to all the stakeholders in the education community so that it's easily accessible, and we're also sending out information -- I know Assembly Woman Nolan is very interested about information for parents. So it's a constant day-by-day thing. Continuing to need to do more.

I can tell you in my agency, we have posters and other things to remind us of good hygiene as well as hand washing techniques. It will be a continued press from all of us to make that happen.

CHAIRMAN GOTTFRIED: It seems to me, if someone discovered tomorrow that there was an ingredient in the Tempura paint that kids use in school art classes that that killed six children in our schools last year, there would be a humongous outcry to deal with that.

There are probably at least a

hundred times that number of school children who die of influenza each year in New York State. Now maybe it's because that happens every year and things that affect hundreds of people don't get anywhere near as much

press attention as things that affect six people, but it seems to me there ought to be something massive going on.

MS. STEVENS: I believe that the school administrators, teachers, faculty across the state understand that children's health and safety comes first before anything else.

When Dr. Daines and I did the town hall meetings as well as the press events after that, we were in schools and we saw evidence of quite a bit of that. In addition, we've seen more and more that many of the school districts when they had their opening day events, staff were brought up to speed on what the actual activities the various school districts were taking in terms of making hand sanitizer, hot water, soap and those things available. And also

very simple fact sheets and guidance that can be used.

One of the documents that we produced is really preparing for H1N1 K12. This is distributed to all people either electronically and downloadable. We've answered lots of questions. I'm responsible for student support services health and we

continue to do that.

Again, constantly needing to do more, but I can tell that you there's a great deal of information that's been shared with schools and we can see physical evidence of that.

ASSEMBLYWOMAN NOLAN: Jean, thank you. It's always good to see you.

MS. STEVENS: Nice to see you, assemblywoman.

ASSEMBLYWOMAN NOLAN: We do appreciate everything that you do.

I just have a quick question about how many schools were closed in the rest of the state?

MS. STEVENS: I'm sorry,

assemblywoman, I don't have that exact number for you, but I would be happy to get that as a follow up.

ASSEMBLYWOMAN NOLAN: Was it anywhere near approaching the city's number of 60?

MS. STEVENS: I don't believe that it was.

ASSEMBLYWOMAN NOLAN: I know there was some in Rockland and Nassau which

would make sense since they were in the city.

MS. STEVENS: Buffalo. It was geographically dispersed. But I can get the exact numbers and locations if that would be helpful.

ASSEMBLYWOMAN NOLAN: Does SED have a similar website to what the City's talking about where it says if there are more than five children out with H1N1 or flu-like illnesses, you can look it up?

Although I have to say, I was relieved to find that it actually isn't up because there haven't been any, because I

look for things like that.

MS. STEVENS: Yes. We actually have worked with the Department of Health. We have a voluntary student absenteeism surveillance form that we have been collecting and so far we -- similar to the city.

ASSEMBLYWOMAN NOLAN: And is it postable? Can I find that if I ask my staff to find that on your website they can find that?

MS. STEVENS: It's reported to us daily. I will check to see what the

public's access is to that as a follow up. I'll be glad to do that.

ASSEMBLYWOMAN NOLAN: Thank you.

MS. STEVENS: You're very welcome.

ASSEMBLYMAN LANCMAN: Does SED have a policy as to which schools should have a healthcare professional in them, what categories of schools?

MS. STEVENS: I think that right now, whether or not a school district has a

nurse -- varies across the state, but, again, there are some specific guidance materials that are provided for school administrators but similar to your earlier discussion regarding cities in New York City, not all upstate schools have a registered nurse.

CHAIRMAN GOTTFRIED: Thank you very much.

Our next witness Merline Smith, Chief Disaster Preparedness for New York State Insurance Department.

(The witnesses were sworn.)

CHAIRMAN GOTTFRIED: Which of you is --

MR. FELICE: Merline is going to give the testimony. I'm here for any questions that come up about insurance coverage. Merline will introduce me.

MS. SMITH: Good afternoon. We would like to thank the assembly for asking us to testify at this public hearing.

My name is Merline Smith and the I'm the Chief of the Disaster Preparedness

and Response Bureau for the New York Insurance Department.

I'm here with Lou Felice who is the Deputy Chief of the Insurance Department's Health Bureau.

The role of the Insurance Department is different than that of the Department of Health.

We are not involved in distribution or administration of the H1N1 vaccine, but we have been working with health insurers to clarify what costs associated with vaccine and treatment will be covered and to try to make sure to the greatest extent possible that financial barriers to accessing the H1N1 vaccine are minimized.

In an effort to minimize public

health, infrastructure, and financial impact of H1N1 virus, Departments of Health and Insurance sent a joint letter on August 14th, 2009 to all private health insurers strongly encouraging them to work with the state to prepare for the fall flu season.

The letter identified five goals for ensuring that New Yorkers have access to needed care and treatment. First, ensure that as many New Yorkers as possible are vaccinated for the H1N1 virus.

Secondly, ensure that as many New Yorkers as possible are vaccinated for seasonal influenza. Third, asking insurers to review and augment drug coverage and formula requirements to ensure access to anti-viral drugs that are indicated for influenza prophylaxis and treatment.

We also would like them to consider additional actions to plan for an active fall flu season such as providing educational materials, developing a plan to communicate pandemic related changes in policies to enrollees, regulators, providers, employers and the media, and establishing dedicated toll-free hotlines,

dedicated websites, recorded messages or other methods of communication.

We also ask the insurance companies stay well informed and coordinate

with the Departments of Health and Insurance since information about H1N1 will likely develop over time.

In order to advance these goals, the insurance department is actively working with the health insurance industry, focusing on two aspects of the H1N1 virus; immunizations and treatment.

Insurance coverage for immunizations. As you know, the H1N1 vaccine is being purchased by the US government and will be made available to vaccinators at no cost. Syringes, needles, sharps containers and alcohol swabs will also be provided at no cost.

State Health Departments and a few separately funded cities will direct their allocation to local Health Departments and other vaccination partners.

The Department of Health advised that New York intends to use a combination of public and private sectors to ensure that New Yorkers are vaccinated. While the cost

the vaccine itself will be free to patients,

private health care providers can charge a fee for administering the vaccine.

The insurance department met with trade associations representing health insurers who agreed that the administration fee to the provider for the vaccination should, in most cases, be covered by health insurance.

Under the child wellness mandate, insurers must cover well child visits and vaccinations recommended by the Advisory Committee on Immunization Practices. This year, the ACIP has advised that children should receive both the seasonal flu and H1N1 vaccines.

The insurance department issued clarification that health insurance contracts covering children must cover the H1N1 vaccine without the application of copayment, coinsurance, or annual deductibles.

While there's no required coverage for adult vaccination, the insurance department has met with the health

insurance industry concerning this issue and is strongly encouraged that health insurers have agreed to reimburse the fee for administration of the vaccine.

In addition, the insurance department met with the New York State Medical Society and is encourage that MSNY will advise doctors that they should not charge a copayment when the only reason for the doctor's visit is for the H1N1 vaccine.

If the patient receives treatment other than the vaccine, the doctor may charge a copay for an office visit.

In addition, both the insurance and health departments requested that insurers provide subscribers with alternate locations where they can receive the H1N1 vaccine if their primary care physicians have not preregistered for an allotment of the H1N1 vaccine, or if their PCP is too busy schedule a visit.

Subscribers should also check to determine whether their provider is in network or out of network. Different

coverage rules may apply. For instance, if you go to an out-of-network provider, administration fees may go toward your deductible and, therefore, you have to be paid out-of-pocket.

This may be particularly important if you cannot schedule an appointment with your PCP and have to go to an alternative provider.

We are encouraging health plans to work with subscribers to find alternative vaccination sites, if necessary, and to make subscribers aware of the costs associated with seeking such services.

The insurance department continues to work with the Department of Health, health insurance carriers, and the medical community to ensure that insurers provide information to subscribers on how to get access to the H1N1 vaccine.

I'm going to speak about insurance coverage for medical treatment. The insurance department is also working with health insurers to limit financial

barriers to receiving flu treatment. One of

the goals identified in the August 14th, 2009 joint Department of Insurance, Department of Health letter, is that health plans review and augment drug coverage and formulary requirements to ensure access to antiviral drugs that are indicated for influenza, prophylaxis and treatment.

While there's no guidance for using antiviral drugs as a prophylaxis, the CDC issued guidance on the use of antiviral drugs for treatment to lessen the symptoms for those exposed to H1N1.

The insurance department strongly encourages the health insurance industry to support this public health initiative by making the necessary adjustments to internal policies so that the insured population can receive recommended treatment in a timely manner without financial barriers.

The insurance department is also encouraged that health insurers have promised to allow subscribers to receive antiviral drugs at the lowest tier of drug

formularies.

In addition to discussions concerning changes in internal policies to augment drug coverage for antiviral drugs,

the insurance and health departments request that health insurance provide subscribers with information concerning alternate treatment sites if they are unable to see their PCPs.

This is similar to our concern that alternative sites be available for vaccines. But it is somewhat more complicated because it involves medical treatment. There is concern that patients will go to emergency rooms if they are unable to see their PCPs, which may overburden the resources of the emergency rooms.

The insurance department is encouraging insurers to use existing communication mechanisms to advise subscribers what to do if they need treatment for influenza.

Such information should be

include where to call for referrals to nearby urgent care facilities and providing a listing of federally qualified health care centers where patients can receive in-network treatment.

Discussions are ongoing to ensure

provider networks will have the capacity to accommodate a possible surge in the number of persons seeking treatment for the flu.

In conclusion, the insurance department continues to collaborate with the Department of Health, the Health Insurance Industry and health care providers to minimize, to the greatest extent possible, any financial or administrative barriers to patients getting either immunizations or treatment of the H1N1 influenza.

Thank you again for inviting the Insurance Department to this hearing. We would be happy to answer any of your questions.

CHAIRMAN GOTTFRIED: Thank you. I guess just one observation that may relate to some other issues on the public's agenda

these days.

It seems that government involvement in health coverage can do some good.

Are you aware of any efforts by insurance carriers not only to communicate information to patients about vaccination and treatment, but also to try to promote other prevention mechanisms? It would seem

to me an insurance carrier would have a financial interest in promoting simple preventive measures.

I'm just wondering whether any of them are doing mailings to their subscribers, et cetera, along those lines,

MS. SMITH: I haven't seen any mailings, but we did look at certain websites to see what information was out there and most of the insurance companies do have information on the websites where the person can go and find out where they can get vaccination along with additional information about hygiene, hands washing, covering your cough, if you're ill, stay

home, and always reminding the subscribers that they need to contact their PCPs if they become ill and need treatment.

MR. FELICE: In addition to that, all of the websites generally linked to the CDC site and recommendations there and that's a good practice, and part for self-interest because it does tie to the coverage issue. They want to cover what the CDC recommends, but also, all of these insurance companies and health carriers have

to file with us disaster plans for their own account. So they need to put that information out there not only for their members but for their own employees because, you know, obviously their ability to function during a pandemic can be like H1N1, can be affected by how their employees behave and what preventive actions they take.

CHAIRMAN GOTTFRIED: Other questions?

ASSEMBLYWOMAN GLICK: What kind of response did you say that you had gotten

from insurance carriers?

MS. SMITH: Surprisingly, they have been very cooperative. It's surprising but it's also not surprising because if they don't start with prevention, the end result is they have to pay for treatment.

So for those companies who do not have vaccination coverage for adults, they're even offering to cover it because they realize that the prevention is the first step. We've heard several speakers hear say, the first thing you need to do is get vaccinated. So the insurance companies are on board and will cover the

administration fee. Wonderful reception.

MR. FELICE: As far as vaccination goes, I think the industry really recognizes the value of that. We're continuing to work on the coverage aspect outside of vaccination with the industries, it's still a little steep than their protocol in how they treat outer network items from the treatment perspective.

I think they do understand that

we're trying to keep people out of the emergency departments and it's in their benefit to do that.

And the department, of course, is willing and has, especially in the wake -- specifically in the of 9/11, you know, offered to waive certain of our requirements on insurance companies around prompt pay and utilization time frames in order to allow their systems to catch up with what's actually happening in terms of treatment on the ground. So still work to be done, but some encouraging signs.

CHAIRMAN GOTTFRIED: Okay. Other questions?

(No verbal response.)

Thank you.

Our next witnesses are Ed Engelbride from the State University, Kathleen Camelo from SUNY Plattsburgh, and from Columbia University, Thomas Palatucci, and Marcy Ferschneider. I hope I haven't mangled anyone's name too much.

(The witnesses were sworn.)

DR. ENGELBRIDE: Good afternoon. Assembly Members Gottfried, Nolan, Glick, Lancman and distinguished members of the Assembly.

My name is Ed Engelbride and I'm the senior assistant provost for University Life and Enrollment management at the state university. And on behalf of our chancellor, Chancellor Zimpher, I'm pleased to have this opportunity to provide information about the state university's efforts to protect the health and safety of our students.

With me today is Dr. Kathleen Camelo who is the director of the student health center at one of our campuses at Plattsburgh. In addition to being the student health center director, she's also the president of the student health services

council which is a professional organization within the State University.

As you're aware, the State University serves a diverse student body of over 430,000 with over 80,000 living on our

campus residence halls, and I'm pleased to begin reporting that, so far, H1N1 flu has had a minimal impact on our students.

Due to the potential seriousness of the H1N1 virus and the possibility that it could disproportionately affect our campus populations, last month Chancellor Zimpher directed our campus presidents to report on a daily basis the number of students with symptoms of ILI, or influenza-like illness, and they're reporting that information to us at sytem administration.

An internal system has been developed to gather and analyze this data and we're monitoring it daily. This information provides us with valuable situational awareness to identify early changes in H1N1 incidents, and with over 430,000 students, most campuses are reporting zero to less than five new cases

of ILI per day.

For the most recent week, the average daily number of new cases of ILI

within the State University was 83. In addition, Chancellor Zimpher has formed a special SUNY H1N1 Medical Advisory Group consisting of physicians and other health experts from SUNY's academic health centers, student health centers, and this group includes internationally known experts on infectious diseases, public health, and other disciplines.

This group also reviews data reported by campuses and advises system administration regarding necessary follow-up.

The reporting system and the medical advisory group compliment existing efforts within the State University to respond to issues like H1N1.

Specifically, in order to monitor and respond to the flu, this past spring we called together our existing University Wide Emergency Management Group that's comprised of campus experts in the student health services, environmental health, emergency planning, and university police.

This group was able to quickly build upon the work that we did in 2006 to prepare for our Avian flu, which, thankfully, never arrived or hasn't yet, and in 2008, we implemented a requirement through a university wide procedure that campuses have to have a section on pandemic flu in their emergency response plans.

Those earlier efforts helped us as the H1N1 virus began to spread across the country and campuses started to implement their emergency response plans.

This group has been meeting regularly to provide guidance to our campuses, monitor information from the Centers for Disease Control and Prevention, and to coordinate with state agencies such as the Department of Health, and the State Emergency Management Office.

One of the very first efforts of this group was to issue a series of guidance documents that we sent to campuses to assist them in their local planning, while these documents were initially drafted in 2006,

they were revised to include specifics regarding H1N1.

These documents covered the following topics; suspension of activity on campus, social distancing, hard to do on a college campus, travel by students, faculty and staff during a public health emergency, use of facilities for emergency purposes, essential functions during an emergency, and the stock piling of supplies.

The university also modified and reissued an overall planning template that dealt with the pandemic flu.

Last month we held a very successful symposium on H1N1 flu for our campuses that attracted over 167 participants from 54 of our campuses. Speakers of that event included people from the CDC, the Department of Health, as well as the American College Health Association.

The person who is in charge of acuity on pandemic flu planning is from Carnegie University, and she offered some first-hand advice on some issues since they

had had an outbreak on their campus.

Presentations and discussions covered a number of topics from procedures for acquiring the vaccine to the legal ramifications should a flu outbreak take place.

Finally, workshops were help at our Utica campus and our Farmingdale campus on respiratory protection including fit testing protocols for the use of respirators and many campuses participated in these workshops.

I would like to now turn the microphone over to Dr. Camelo.

DR. CAMELO: As you know, influenza-like illness includes a broad range of symptoms including a fever and a cough or sore throat, can also include runny or stuffy nose, body aches headache, chills, fatigue, vomiting or diarrhea.

Students with several of these symptoms could be classified as having ILI, influenza-like illness. It is important to point out that not all students with

influenza-like illness have the H1N1 flue virus. These symptoms are the same as those

for seasonal flu and we are quickly approaching, if not already in the first waive of seasonal flu when counts start to increase.

As previously stated, reported incidents of influenza-like illness on SUNY campuses has so far been low. A university-wide informational website was made available for sharing information related to the H1N1 flu with recommendations for limiting the spread of the disease among individuals, links to other websites such as the CDC and the Department of Health, and specific references to guidance for colleges and universities. This website complimented the websites that most campuses also established.

As you know, the H1N1 vaccine will be available over the next few weeks. Our campuses have been working closely with their local county health departments to be able to provide the vaccine to our campus

communities.

While a number of steps have been taken at a university- wide level, campuses are at the front line of dealing with this disease. Our campuses have engaged in many

efforts such as providing prevention information in various formats, enhanced education and outreach to their campus communities, implementation of protocols to reduce transmission, expansion of respiratory protection efforts, review of emergency planning protocols, increased surveillance to identify ill students, protocols to support ill students and work with family members, and exploring alternative housing for our ill students.

We have taken many actions to prepare for and respond to the 2009 H1N1 virus. We hope that we will not need to take additional steps but we are ready if it is necessary to do so.

DR. ENGELBRIDE: We'd be glad to answer any questions.

CHAIRMAN GOTTFRIED: Why don't we

hear from the two folks from Columbia and then we can do questions together.

MR. PALATUCCI: Good afternoon, assembly members. I'm Thomas Palatucci,Chief of Administration for Health Services at Columbia and I'm here with my colleague Dr. Marcy Ferschneider who is the

director of primary care medical services.

CHAIRMAN GOTTFRIED: Could you speak just a little louder?

MR. PALATUCCI: Will this help? Okay. So I am Thomas Palatucci, Chief of Administration for Health Services at Columbia, and I'm here with my colleague Dr. Marcy Ferschneider who is the director of primary care medical services on the Morningside Campus of Columbia.

Columbia has been monitoring and responding to the H1N1 outbreak since this novel flu strain came to the attention of public health authorities this past April.

In fact, preparations for just such an event have been ongoing for the past several years through the efforts of the

university's pandemic preparedness workgroup. Out of this came the pandemic response plan which provided a road map for university preparations as the nature of this outbreak became known.

Also starting in April, a larger group of members from the university community have been communicating via regularly scheduled teleconferences. Out of these meetings come decisions on how best to

provide information, and keep abreast of developments and recommendations of the New York City Department of Health and Mental Hygiene, Centers for Disease Control and the World Health Organization.

More recently, the group has coordinated the support of students showing evidence of influenza-like illness and efforts to minimize the transmission of the virus.

To ensure a coordinated response, these teleconferences include participants from the Morningside Campus of Columbia University, Barnard College and Colombia

Medical Center, as well as three nearby institutions of higher education, Teachers College, the Jewish Theological Seminary, and Union Theological Seminary.

A key early decision was to communicate primarily through the university's website which can be found at www.Columbia.edu. This, in turn, provides access to the university's pandemic preparedness page and student health service.

By providing regularly updated

university specific information, as well as direct links to the New York City Department of Health and Mental Hygiene, CDC, and World Health Organization, we are in concert with these agencies.

In the week ending October 10th, these two sites which are also available to the public at large, received over 57,000 hits. That's actually down from over 70,000 at the end of September.

As a full term approached, the university e-mailed students, parents and

staff, sharing information about the university's response to the pandemic and encouraging ongoing use of the pandemic preparedness and health services website.

The Health Service also established a call center in anticipation of greater phone volume as students returned to campus. This student resource is available 24 hours a day, every day, and allows the health center to triage ill students respond to general inquiries about flue and continue its regular services.

Students diagnosed with influenza-like illness are counseled to self isolate by remaining in their rooms or

returning home if that is feasible.

Arrangements can be made to provide meals and the health service follows up with students who are at risk or experiencing severe illness. Following current recommendations, students are advised to self-isolate until fever free without the aid of medication for 24 hours.

Similarly, university staff who become ill are advised to remain home until they have recovered, and, again, following current recommendations have been fever free for 24 hours.

While responding to the H1N1 pandemic, the university also continues its regular practice of offering free seasonal flu vaccinations to students and staff. These flu fears began earlier this month and will continue through November. The dates and locations are announced on the health service website.

We have also registered with the New York City Department of Health and Mental Hygiene to dispense H1N1 vaccine to students and staff once it becomes available.

As we've already heard this morning, the two vaccines can be administered during the same encounter, so once the H1N1 vaccine is available to us, we will incorporate it into our seasonal flu planning and schedule additional dates as needed.

The university continues its efforts to protect the Columbia community from avoidable risk of infection as much as possible and maintaining morale during the pandemic. For those who become ill, we look to make sure every member of the Colombia community, students, faculty and staff, receive medical attention and appropriate care.

The university also communicates with faculty, staff and students on a regular basis and seeks to provide the best known information. Our health service always coordinates with our colleagues in the larger healthcare system, the New York City Department of Health and Mental Hygiene and other appropriate governmental agencies.

It is essential that the university act in concert with other resources in the city and region to minimize

confusion, assure the wise use of resources and provide the university community with updated and accurate information.

In this light, we appreciate the

opportunity to address the state Assembly and I'd like now to turn this over to Dr. Marcy Ferschneider.

DR. FERSCHNEIDER: Thank you.

Since the start of this academic semester on September 8th, 2009, health services have been collaborating with the Departments of Housing and Dining to ensure the health and safety of our students.

Primary care medical services, the medical branch of health services on the Morningside Campus of Columbia University has been on the front line of both identifying and subsequently caring for those students with influenza-like illness as defined by the CDC to mean fever plus cough or sore throat with no other identifiable cause.

Since September 8, 2009, primary medical care medical services has experienced a 16 percent increase over the number of patients seen during the same

period last year, and we continue to have an incidence of influenza-like illness of

approximately two percent.

Additionally, we have already administered half the number of flu vaccines for seasonal flu that we did during the entire flu season last year.

We are also currently a sentinel site for the New York City Department of Health and Mental Hygiene and are a contributing school to the American College Health Association weekly influenza report.

Thank you.

CHAIRMAN GOTTFRIED: I just want to make one observation.

I think Columbia University and the Ryan Health Center are the only two private sector employers-service providers who asked to testify at today's hearing. So I want to commend you for that.

Questions?

ASSEMBLYWOMAN GLICK: Yes, just a few. It seems as though you have 80,000 students in resident halls but a larger number, 400,000, so are those -- how does that break down, is the large number that

aren't in residence halls reflective of the community college population, or is it a mix of the community college commuting students, plus some number that are living out of residence halls, and how large is that number and how do you reach them?

DR. ENGELBRIDE: That's a very good question. We wonder sometimes ourselves.

On the community college side, we have approximately 18 of our community colleges have residents halls, but still --

ASSEMBLYWOMAN GLICK: That's a small number, because resident halls are not very large.

DR. ENGELBRIDE: So out of the -- I'll guess approximately 215,000, we may have 12,000 residents. So say we have about 200,000 that are living at home, commuting from home or their place of work, if you will. So that's one group. On the state-operated side, a majority -- if you want to look at this, and this isn't true all for institutions, but a third will

usually live on campus. A third used to live on campus but not now lives off. In other words, they lived on for two years and now they live off for two years, and the other third is our commuters from that community.

We have a number of ways in which we reach students, I don't know if Dr. Camelo wants to talk about that.

DR. CAMELO: Certainly through our website. We've also sent letters home to parents and students, at least at the Plattsburgh campus. So e-mails went out and then actually we did specific mailings for those people that don't have access to computers.

So every student on campus has an e-mail account, so that's how we reach the student population whether they live on campus or off campus.

ASSEMBLYWOMAN GLICK: You have 64 campuses, so you're spread all over.

Is there any particular area where you've seen a spike or is it pretty

much across the board a small number?

What's happening?

DR. ENGELBRIDE: We've been looking at this for about four weeks now, and one of the things that we noticed was that in the western part of the state, at least initially, there was a slightly higher number.

But what we usually do is, when we find out that a campus has, say, three new student cases on Tuesday and then reports 15 on Wednesday, we give them a little call and say, what's the reason for the increase and usually it's our campuses are being over cautious and are reporting anyone who may have flu-like symptoms.

And, of course, we ask the question, is it exam time now or was a paper due, or -- so we do call the campus to find out.

But since we looked at that last week, that number has dropped back down and they're all bumping around the same numbers.

ASSEMBLYWOMAN GLICK: I've been

going to some of the campuses, and it may be that when I'm in session, I'm not as observant when I'm flying through a campus,

but it seems to me that over the summer, in August as you were gearing up for the new year, as opposed to maybe in the spring, it seemed to me that there was much more signage and much more awareness.

Is there something new that you're doing?

DR. ENGELBRIDE: Through the chancellor's leadership, we've brought this to the president's attention that this is something that needs their attention, and usually -- and I don't mean to be critical here, but this is something that a student health center director is always concerned about and working through the chain of command, we're working from the bottom up, as well as the top down.

And I think some of the concerns that were generated by the high numbers in April helped our campuses really get on board and implement some of their emergency

planning protocols.

ASSEMBLYWOMAN GLICK: And is SUNY central providing material that is then disseminated or are campuses sort of doing it themselves?

DR. ENGELBRIDE: Well, we push

quite a bit of information out when we're aware of something that's coming from the Department of Health, we make sure that our student health center directors get it.

Also, we push it out to the vice presidents, and they may not have access to some of the Department of Health information directly. So we're pushing quite a bit of information out through various list serves basically. We've also created our own list serve on ILI for people to ask questions.

ASSEMBLYWOMAN GLICK: If I might, it seems to me that on most campuses, you see a variety of things, particularly as Dick has indicated, as students, not because they're exempt, but because they're sleeping less, they're working harder, are you seeing any consistency across disease types

growing, and how do you differentiate between just your general strep that runs rampant in every resident hall and, if that's the case, what are you doing now that's working more effectively to keep H1N1 at bay that maybe you should be doing all the time to keep other types of infections at a lower level?

DR. CAMELO: Well, certainly right now, and we are in the height of the upper respiratory illness, this is a time, as you can see if you go to your primary care provider that URIs, upper respiratory illness really starts to peak.

We'll also start to see as we get towards exams a little bit of a peak in terms of infectious mono. So that's, of course, the same type of preventive measures that you would take to prevent upper respiratory illness are the same types of preventive measures that you would use to protect yourself from influenza-like illness.

So, yes, we are promoting hand

washing, covering your mouth. We have sanitizers in our residence halls, in our dining hall, in our computer labs. So it's the same preventive measures that we should be taking, regardless of the season.

ASSEMBLYWOMAN GLICK: So maybe we're all going to learn something from this.

I will say from friends who are staff at Columbia that there is better

access to soap and towels than there perhaps is on a regular basis and maybe it is something that all of the schools could address more effectively when we're not focused on a particular virus, but in general.

My observation is that the schools are acutely aware and I think that's great. My concern is that that not be something that we fall back away from because I do think students have a tendency, as we know, as I assume we know, maybe everybody here was a little more studious, but that you run yourself ragged and then

you have to really push when exams or papers are due and that tends to debilitate even the young who don't seem to think that they'll ever get sick.

So thank you for being here and your efforts. I would hope that if we see some change that there would be -- that the Committee on Higher Ed could be notified if there are any dramatic changes that you start to see happening on your campuses because that would be helpful to us in reaching out to appropriate senior management.

CHAIRMAN GOTTFRIED: I have one question.

You were indicating earlier that so far incidents of ILI on the campuses seems to be low. I don't know if you have data gathered from previous years, and I guess this question would go to both SUNY and Colombia, can you compare the rate of influenza-like illness so far this year with what you would have experienced so far in prior years?

DR. FERSCHNEIDER: I think as was already addressed, I think it is a difficult thing when you are on the front lines to be able to determine, is this a seasonal upper respiratory tract infection, is this ILI, there are no diagnostic tools. It's really based on history and physical exam. We are tracking it very closely. We have set recommendations on how to track it this year where in previous years it was really up to the individual provider to call it upper respiratory tract infection, viral syndrome, or any variety of diagnoses that are available.

I think this year, because of all

the education that's been done and because of all the guidelines that have been released, we are acting in concert with our other health professionals. Everybody's really saying fever plus cough or sore throat with no other cause is ILI, and they're using that diagnosis and diagnosis code a little more diligently than they have in past years.

So looking at those numbers compared to that of last year, yes, our numbers have gone up, but is that really a reflection of what we're seeing, I don't think there's any way to really tell. And I think that's one of the -- that's one of the problems in doing this kind of reporting and this kind of tracking, when you look at things like the ACHA surveillance tool, it's really based on the individual provider's assessment of what that patient is coming in complaining of. It's not to suggest that it's not accurate or any less accurate, but that people are using different terminology and that terminology is being tracked in a different way.

DR. CAMELO: And certainly at Plattsburgh, when we looked at ILI from last

year, and depending on how the things will go, we're certainly seeing ILI a little bit earlier than we did in the past, and certainly the numbers last year were relatively small.

CHAIRMAN GOTTFRIED: Thank you

very much. Okay. We're now going to take our promised 1:00 10-minute break. We'll be back shortly.

(A break was taken.)

CHAIRMAN GOTTFRIED: We're going to reconvene. If folks can take their seats.

Our next witnesses are from the United Federation of Teachers, Chris Proctor and Anne Goldman. I'm sorry, pardon me. I read it wrong. You're right.

The next witness is Joel Shufro, New York Committee for Occupational Safety and Health.

(The witness was sworn.)

MR. SHUFRO: Good afternoon. My name is Joel Shufro. I'm the executive director of the New York Committee for Occupational Safety and Health, a coalition

of about 200 local unions in the New York Metropolitan area and about 300 individuals all dedicated to the right of every worker to a safe and healthy workplace.

We are here representing also the New York City Central Labor Council of 1.2 million members in New York City. I'm joined by a member of our staff, Susan McQuade, who has been working on this issue.

When the pandemic hits, the flu hits New York, we will be relying on working people, both in healthcare situations, and those who work with the public, such as transit workers and those in the school system to carry out their professional responsibilities.

These workers need to know that during this difficult and perhaps dangerous time, that they will be provided by their employers with the most protective programs available. They also need to know that the New York State and it's local governments are doing all they can to encourage and require employers to provide them with the safest workplaces.

What we mean by that, that employers need to develop and implement

programs that include a comprehensive

infection control program of which voluntary vaccination, proper respiratory protection against aerosolized particles, and revision of leave policies which are necessary components, along with other necessary components, such as risk assessments, engineering controls, which means ventilation, safe work practices, cleaning and disinfection and identification and distancing or isolation of infectious persons and medical care and surveillance are parts.

As with any effective public health program, these programs must be developed with the full participation of representatives of those affected.

Unfortunately, New York State's Health Department policies and positions are hindering, rather than helping prepare institutions and the workforce for the upcoming pandemic. Rather than work with representatives of the unions who represent workers in the healthcare institutions to develop comprehensive programs to deal with

a wide range of work related health issues posed by the onset of potential pandemic flu, the department has issued mandates without full consultation and participation of those who their policies will affect.

They have compounded the problem by refusing to embrace guidance by agencies like the Center For Disease Control and the Institute and the Institute of Medicine for worker protection. The results of which has been that many workers and their representatives have developed deep suspicion that the health of those being asked to work during this period of crisis will not be provided with adequate protection.

OSHA and the New York State Department of Labor, PESH, have respiratory protection standards that requires employers to comply with the respiratory protection regulations which include providing workers with N95 respirators which followed the CDC guidelines.

Yet, New York State's Health

Department is recommending the use of N95s for a very limited number of workers and recommending the use of surgical masks, which are considered to be ineffective to prevent exposure to aerosolized particles. This has led to confusion among healthcare worker's distrust of government and undercuts the agency's credibility.

I have to tell you, we had program about a week ago, two weeks ago, in which we had representatives from the Department of Labor and the New York City Health Department and it was like one agency saying, we will cite you if you follow the policies that you're currently following, and the other agency not being -- justifying not being in compliance, and if you don't think that that leads to major confusion, the response of the audience was nearly hysterical.

The confusion and distrust is compounded by New York State's policy of mandating that healthcare workers under the health department's Article 28, subpart

66-3, be vaccinated against H1N1 virus as

well as the seasonal flu.

As observed earlier, New York State is the only state in the country with such a mandate. If healthcare workers do not agree to be vaccinated, they'll be fired from their jobs as this regulation makes vaccination a condition of employment. The response by many healthcare workers across the state has been one of shock and anger.

While we at NYCOSH, along with public health professionals, strongly support the implementation of voluntary vaccine programs as an important element of pandemic flu preparedness planning, we oppose a policy which mandates that vaccination.

Outside of New York State, there's little support among experts in the field of public health for mandating a vaccination program for seasonal or H1N1 flu. As Assembly Member Lancman pointed out, Thomas Friedman, now the head of the Centers For Disease Control is among many of

the medical authorities that recommend that this vaccination program be voluntary for all and that includes healthcare workers.

Similarly, government agencies

like the Center For Disease Control, the Society For Health Care Epidemiology of America, the Federal Drug Administration and the American Nurses Association endorse a voluntary approach to immunization.

A mandatory vaccination program cannot replace the need for a comprehensive infection control program. However, we are hearings that in some facilities, workers receive the H1N1 vaccine, will be given masks instead of respirators. This shows a complete lack of understanding of a comprehensive approach to prevention. Just from the simple fact that the vaccine is not 100 percent effective in preventing transmission.

We are greatly concerned that given the health department's failure to recommend appropriate respiratory protection, that health care institutions

will assume that vaccination programs would undercut the need to implement comprehensive worker protection programs.

Finally, employers need to have effective emergency preparedness programs in place to protect their workers' health if

indeed the pandemic flu becomes more severe. The CDC and the World Health Organization urge those with flu-like symptoms to stay at home and that the Health Department has followed suit in that recommendation. But workers won't stay at home if they are going to lose a day's pay and, worse, they will not stay at home if institutions have punitive absence policies which will result in termination.

Consequently, we urge the Assembly and the Senate to enact the Paid Sick Leave Act A3647, which would grant up to five days of sick leave in workplaces with fewer than 10 employees and up to 10 days for those employers with 10 or more employees.

Workers should not be threatened

with losing their job when they are too sick to come to work and especially in the case of a pandemic.

So this legislation is a public health issue as much as it is a worker issue, and if ever there was a time that such a law should be enacted it is now and we urge it's rapid enactment.

Thank you.

CHAIRMAN GOTTFRIED: You were here when Dr. Birkhead was testifying in relation to N95 masks versus simple surgical masks, and cited a recent journal article arguing that the evidence was that they were about equally effective. Is there evidence and if so, can you point us to that? Anything contrary to that?

MR. SHUFRO: The most important study that has recently come out has been the study that was done by the Institute of Medicine which the doctor referred to. The small study that he referred to was done on a very limited number of workers in which there's considerable concern about the

methodology, and it was just one very very small study. I believe that they looked at about 30 workers in the process.

So it is not a definitive study by any means. The Institute of Medicine, which is the most prestigious agency to have reviewed all the literature recently within the last month, came out with a very detailed report in which it recommended the use of N95s at minimum, and characterized the surgical masks as ineffective.

Susan, did you want to --

MS. McQUADE: Yes. I mean, there was a study out of Australia recently which said that yes, N95s are much more protective than the surgical mask. This is a major battle as has been indicated. And what everybody keeps leaving out of the discussion is why is there such a pushback from the Department of Health and others against the N95.

We tend to think that it has to do, and this is our opinion, has to do with cost issues. When somebody wears an N95

respirator, they must be properly trained, they must be fit tested, and these are of the disposable nature, so there is some questions, and it's a big question about cost and availability of these devices.

The Institute of Medicine was called in to deal with this discussion and they came out pretty definitively that the N95 is the way to go. Our health department is saying, they're citing other pieces.

And just to reiterate what Joel said, the city -- the State Health Department can say, well we're recommending to you surgical masks. The Occupational

Safety and Health Administration and our New York State Department of Labor under PESH would follow CDC guidelines which means, while the State Department of Health can recommend surgical masks, facilities can be cited under OSHA for not following what CDC guidelines are.

So it's somewhat misleading. Our feeling is it's somewhat misleading to tell people that this may be all right. When it

comes to the worker protection issues, that's is not the way it's going to be looked at by the enforcement agencies for worker protection, OSHA and the New York State Department of Labor, PESH.

MR. SHUFRO: And worse, when an agency comes into sight, the employer is going to say, look, we're just following what the Health Department told us to do. And, you know, I think that's a very problematic position for an employer to be in.

CHAIRMAN GOTTFRIED: Do OSHA regulations specifically refer to N95 masks or is there an area of interpretation, or -- I mean, I would think as a matter of law, if

you are -- if a person is subject to two regs and one says you must do X and the other one says you may do X or Y, the one that says you must do X controls.

Is there a clear and explicit OSHA reg that says you must provide a given set of workers with N95 masks?

MS. McQUADE: My understanding of

this can be thought of, maybe by the nurses too, is that there's a respiratory protection standard under OSHA which PESH also follows, and they follow whatever the standard guidelines are, which are what the CDC guidelines are on this, which is the use of an N95 respirator, okay, in these cases when you're dealing with patients with influenza-like symptoms.

So, yes, CDC, there are recommendations, but the way the respiratory protection standards are written, they're going to follow whatever the best recommendations are. And that's CDC. OSHA and New York State is not going to follow New York State Department of Health. So it's not a mandate from CDC to follow these recommendations. However, under the Respiratory Protection Standard, they're

going to follow what the best recommendations are out there which are made by our Centers for Disease Control. We accept them as an expert across the board on many things.

I think there has to be some question as to why the New York State Department of Health is not accepting them on this issue. And we have asked that question, as Joel said, at the forum of OSHA. Somebody very point blank said, if there is not compliance with the N95 respirator, can you and will you cite, and the answer was yes. They would follow those guidelines.

CHAIRMAN GOTTFRIED: So you're saying by operation of law the OSHA and PESH regulations --

MS. McQUADE: They're going to follow CDC.

CHAIRMAN GOTTFRIED: Convert a guideline into a legal requirement?

MR. SHUFRO: That's right.

MS. McQUADE: If figuring doing the assessment are what the best respiratory protection is, and what the standard

respiratory protection is as being exposed to whatever the substance is, so, yes. And they look to CDC for -- infection control,

they look to other professional organizations when they're exposed to other toxic substances. I mean, they don't do all that.

ASSEMBLYMAN NOLAN: I assume you're also talking about class of worker. Are you saying that every teacher should have an N95 mask because there's a possibility that someone in the class has H1N1? Are you talking about healthcare workers? Is it specific healthcare workers? Does it mean management, does it mean custodial?

MR. SHUFRO: I'm saying that -- Cathy, the standard requires that employers do an assessment, a job assessment, hazard assessment, of each specific job to see whether a worker is being exposed. And then, based on that assessment, make a determination of what protections is needed.

And that is what we think needs to be done. If you're talking about, for example, a nurse in a school.

ASSEMBLYWOMAN NOLAN: That would

trigger the N95, then so then presumably -- perhaps for cost reasons or others, people will assess the position as not requiring that level of involvement. So it doesn't really conflict. I have to be -- respectfully, it doesn't really conflict with what OSHA and what the State Health Department did, because the reporting, you know, employer will classify the job title.

ASSEMBLYMAN LANCMAN: If it would be helpful, why don't I just read you what the CDC said.

This is the CDC interim recommendations for face mask and respirator use. For home, community and occupational settings, for non-IL, influenza like, non-ill persons to prevent infection with 2009 H1N1. It says, persons not at increased risk of severe illness from influenza, non-high-risk individuals should use a respirator "when caring for persons with known probable or suspected 2009 H1N1 or ILI. And then caring, this is the key part, caring includes all activities that

bring a worker into proximity to a patient with known probable or suspected 2009 H1N1 or ILI including both providing direct medical care and support activities like delivering a meal tray or cleaning a patient's room. So it's very very -- according to the CDC, it's very very broad about when somebody should be wearing a respirator.

MR. SHUFRO: Right. And if an employer does the job-hazard analysis and says, no, you're not going to be required, and then the worker then calls OSHA or PESH, then that employer would be cited.

ASSEMBLYWOMAN NOLAN: But we've had this with other issues, they'll say the dietary people leave the meal at the end of the room, they'll only have a special -- there are ways -- I'm not disputing that we should have more N95 respirators. I always want to be supportive, and I have a lot of respect, Joel and I go back a lot of years, but I think we have to acknowledge, and I don't want to take issue with what you said,

but I think have you to acknowledge that there is -- it's not a complete, DOH did this, OSHA says that, slap. It's not, you know, the employer plays a role in classifying the positions and that's how they will -- I hate to use an expression "get around it" but that's how they will be able to deal with these competing agency regulations. It certainly is a path that an employer could take.

MS. McQUADE: I think that there are classes of workers that are being considered by the Department of Health who they would have wear surgical masks as opposed to N95s. That we have been told by both OSHA and PESH that if they are called, they'll be sighted for doing so. And so it's not just --

ASSEMBLYWOMAN NOLAN: That's a different thing from what I just said. I said there are people -- you're saying that if a position has been designated -- I don't want to say hazardous, but contact with a patient with H1N1, then the less

can -- the employer has some ability to classify the position.

I'm only also looking at it from the Education Committee point of view. You're not going to outfit every teacher in the city with an N95 respirator. It's just not going to happen. I so I understand the idea of classifying the physician. That gives the employer some ability to define it.

MS. McQUADE: But it's based on the exposure.

ASSEMBLYMAN LANCMAN: The key issue that would be in schools, I think, would be -- in a school where you have a school nurse or school health aid, some healthcare professional, that is the person who is supposed to be the one who will be interacting with kids who have H1N1 or influenza-like illness symptoms. Does that school nurse or health aid get an N95 respirator.

ASSEMBLYWOMAN NOLAN: But it's not enough to give them an old style surgical mask. So that I agree.

ASSEMBLYMAN LANCMAN: Well, if you look at the CDC guidelines, it would

seem to say that those individuals should get a respirator, but if you look at the Department of Health's guidelines, it would seem to say that those individuals only get a mask because they're not engaged in certain aerosol inducing procedures.

MR. SHUFRO: Yes, that's right. And you will have a representative from the UFT to talk about how they view the use of respirators in schools.

MS. McQUADE: Right. But just to note, a hospital in Queens was cited this spring for not being in compliance for not having the N95 respirators.

ASSEMBLYWOMAN NOLAN: They can cite them for a lot of things.

MS. McQUADE: Right, so what I'm saying is, it's not like it's without precedent.

CHAIRMAN GOTTFRIED: It would be useful I think if when you get back to the office if you could e-mail to us and if you send it to the e-mail address on the hearing notice, we'll distribute it among everyone, I would say a link to the IOM report and the CDC guideline, and the regs that you're

referring to, I think it would be useful certainly to me and I think the others to be able to see them in black and white.

ASSEMBLYWOMAN NOLAN: What's the cost factor? Do you have any idea? I'm not going to hold you to it.

MR. SHUFRO: We don't know because the respirators do cost money, but it's also that workers need to be trained, fit tested.

ASSEMBLYWOMAN NOLAN: Do you have any idea or can you get back to us with what the cost of the training and the actual object, the actual --

MS. McQUADE: Right. We can get back to you.

And if I can just say one thing.

This is an old time -- this reminds me well what happened with HIV years ago when it was just when we talked about, oh, it's just the nurses and the doctors that are exposed. It's nobody else, and what we learned -- and that we can't afford to get safer needles, and we can't afford gloves and we can't afford any of this and that was the modus operandi back in 1985 when this all broke.

So as an old timer, I see this

as, we're at the beginning of the cusp of this. This is a change that's got to come to healthcare around the use of N95 respirators, and the data is going to support this as time goes on.

But the ultimate point we want to make is, if we know this is the best way to protect healthcare workers, why aren't we doing it? It's there and let's figure out how to provide that protection along with voluntary vaccination programs.

CHAIRMAN GOTTFRIED: Don't go yet. By the way, my wife is a nursery school teacher who teaches three-year olds,

and if healthcare workers need N95 masks, I think she needs a HAZMAT suit. If you've ever been around a couple of dozen three year olds with runny noses, it's disgusting. And their parents, no matter how many times you tell them, do not keep them home when they're sick.

On the question of the vaccine regulation, I don't know for how many years it has been a mandate for the healthcare workers we're talking about to have measles and rubella vaccination and the TB test.

I don't think anyone has ever come to me expressing outrage about that or asking me to write to the health commissioner demanding that that be made voluntary. Maybe now that I've said that, people will, but they haven't so far. Am I missing something? Is this vaccination different, and, if so, how?

MS. McQUADE: The nurses will answer that.

CHAIRMAN GOTTFRIED: Let's hold off on the outbursts, you'll all have a

chance to testify.

MS. McQUADE: My background is in public health education. There are a variety of reasons, and I'm going to let the nurses answer most of them. I don't know, but I don't know if the process by which the measles, mumps, and rubella vaccination came in was different. I would suspect it was. There was wide consultation.

Did somebody say it was a legislative action? It wasn't. It was just -- but it wasn't an emergency regulation, was it, as this is?

CHAIRMAN GOTTFRIED: Probably not.

MS. McQUADE: This is an emergency regulation saying this is because I have an emergency that we need to do it. I do not believe and I don't know for sure but I do not believe that was what happened with measles, mumps, and rubella, and TB.

ASSEMBLYWOMAN NOLAN: I think if my memory, because I'm an old timer too, serves me right, tuberculosis, it was an

emergency regulation, but we have staff that will check that out.

CHAIRMAN GOTTFRIED: Although in the Pataki Administration, every health department regulation was done as an emergency regulation.

MS. McQUADE: And it was done, I believe, I stand to be corrected, as someone enters the work force, right? You have situations, we have nurses on the phone who have been working for 30 years who are suddenly being told that they must get this vaccine now or they will be terminated. I don't believe that is what was happening back with measles, mumps, and rubella.

And it's a titer. It's a titer, so it's checking to see if indeed they have

been -- they have antibodies to protect them against this. Most people received the measles, mumps, and rubella when they're children and not when they're adults.

CHAIRMAN GOTTFRIED: Other than the way people feel about it, is there some difference between being mandated to have a

measles and rubella vaccination and being mandated to have a seasonal flu vaccination?

MR. SHUFRO: Well, we'll let you hear from the nurses, but our concern is this. The whole discussion has been around this regulation as opposed to the wide range -- developing a comprehensive program which is important. The vaccination is between 70 to 90 percent effective from what we understand. That means that 10 to 30 percent of workers who are vaccinated can still be ill.

So that providing the vaccination, requiring the vaccination is not going to result in the prevention of the transmission of the disease. And that there are wide range of programs including respirators which are as effective.

I mean, we're normally an organization that looks at administrative

controls rather than requesting and requiring personal protective equipment. Those are the -- using personal protective equipment is always the last line of

defense.

In this case, because of the nature of the vaccination, which, again we support fundamentally, but as a voluntary basis, on a voluntary basis, we think that you have to have the other components of the program in place. And the failure of the Health Department to get people to take the vaccine, we think is a result of their program.

I mean, if you had the gentleman, the doctor talk about his consultation program with the unions, he cited that they may have met with a representative, he was very clear, a representative, perhaps about a year ago in a meeting that was called for another subject, and that's what they called consultation.

You cannot build an effective public health program, vaccination program with that sort of communication. It goes just to the opposite extreme. I think that

that's part of the reason their program has not worked.

MS. McQUADE: I checked on line, someone sent me the link to the public health review commission. I did not see a single name of a single organization, work organization. It may have been not the same list, but somebody sent it to me and I went through the entire list and I did not see it.

So, again, whatever that procedure was and even in an emergency regulation, to include stakeholders is something we're also exploring and discussing.

CHAIRMAN GOTTFRIED: Any other questions?

ASSEMBLYMAN LANCMAN: I just want to thank you for all the help that you gave me in putting together the H1N1 in the workplace report.

Before you leave the table, do you know what Dr. Birkhead was referring to when he said that the CDC was coming out with modified guidelines on the respirator issue next week?

MR. SHUFRO: These guidelines have been promised for about the last month, yes, and we are told tomorrow, tomorrow, tomorrow. I think it reflects a huge political fight that's going on at the higher levels of government over the level of respiratory protection and we, you know, we hear from both sides that they're going to prevail.

MS. McQUADE: We'll see.

CHAIRMAN GOTTFRIED: Okay. Now, the United Federation of Teachers.

(The witnesses were sworn.)

MS. PROCTOR: Good afternoon. First of all, we want to thank you for the opportunity to testify here today. My name is Chris Proctor. I'm an industrial hygienist, and Safety and Health Department Coordinator for the United Federation of Teachers.

I'm here with my colleague, Anne Goldman, who is a special representative and registered nurse for the Federation of Nurses and the United Federation of

Teachers.

Our union represents approximately 200,000 members including New York City public school educators and several thousand hospitals and Visiting Nurses.

I'm going to speak first to the school setting and Anne Goldman will speak about the hospital and Visiting Nurse and other healthcare facility settings.

Since the very beginning of last spring's flu epidemic, the UFT has worked closely with the New York City Department of Ed and the New York City Department of Health to put in place flu preparedness plans and protocols. And, as a result of our joint collaboration, and also in response to lessons learned from last spring, and there were a number of lessons, more comprehensive plans and protocols are now place.

And the city described these earlier, but there are three key components and the first one is infection control, flu

education and prevention campaign, and they

outlined a number of things that they're doing, and I won't repeat that, but, for example, it's very important to get the message out that if your child is sick, your child should stay home.

If sick students arrive at school, they will be isolated and that's part of the plan. One of the things that had happened in the past, if a student was ill, often that student may be returned to the classroom or to the general office until parents or the guardian could come.

They are now either in the nurse's office or what they call a designated overflow room. So that's the first component. Infection control, education, prevention.

A second component is monitoring, surveillance monitoring, and what's going on with influenza-like illness in the schools. As a result of the UFT's urging last spring, the City Department of Ed and Department of Health began posting publically their

criteria for monitoring and for closing schools and posting daily influenza-like illness rates.

We are very happy that they are continuing this in this year's plan. We think that goes a long way to provide the entire school community and the public with very important information about what's happening in the schools.

The third component, which is new, is the vaccination program. That's a voluntary vaccination program, as you heard, for New York City public school students as well as non-public school students, which they also talked about. So we do feel that the plans this year are much more comprehensive and include very important critical improvements.

Nonetheless, we do think the city needs to go further and we have additional recommendations. We recommend that there be a school nurse in every school building. We also -- one of the issues that came up, we want sick staff to stay home also, but there

were staff who did not have sick days in their bank and, so now, what do you do? We also had staff at risk for complications from the flu, including pregnant staff, and, in certain conditions, they were urged by their doctors to stay home. Now you have to

make a choice, do I stay home? I have no days, what do I do? Do I follow my doctor's recommendations? We also recommend paid sick days in the private sector so parents can stay home with sick children, and we also want to see N95 respirators and a respiratory protection program for nurses and personnel, staffing, those rooms where you have students with influenza-like illness.

We recommend making the vaccine available to our school staff on a voluntary basis. Making sure that it goes first to those staff members who are especially vulnerable, namely pregnant women and those who have chronic health conditions. That's the school setting.

I'm now going to turn it over to

my colleague Anne Goldman who will talk about the healthcare setting.

MS. GOLDMAN: Thank you. As we proceed down this discussion, and I'm sure you will hear today from my colleagues and other unions, the issue before us is indeed to have a comprehensive, far-reaching program, not a silver bullet, which is not

insured, with a vaccination program, but, indeed, the continuity of education. The prevention of public health outbursts is communication and education, not mandation.

Indeed, the isolation of contagious patients is the first step. We then proceed to the adequate and appropriate supplies. Not unilateral decisions by employers which are shaped by the economic needs, by the whimsical approach to the disease which moved our state to mandate our frontline workers, interestingly enough, there's no mandate on the safety equipment we are given to use.

In addition, as we proceed with the respiratory protection program, we

cannot emphasize enough the variety of components of educating to the prevention and identification in the public arena of how these germs, the epidemiological prevention, if you will, of how we can be effective.

By the way, the best vaccination in the world will do nothing if we have a different strain, which has been our custom in our city which indeed entertains transportation by the minute from

individuals from other countries. To have started with the population and the workforce to be mandated without regard to the individual's physical ability to respond to a vaccination program, knowing full well the average age of health workers is into the 50s, which means autoimmune systems, histories, and the variables we hold dear in America, and in New York, about individually identifying the appropriateness of a vaccination program, have been stripped from us for no reason other than a panic, and a panic which does not ensure public health.

We are greatly concerned because this is not tried and true. We have over the years, those of us who came, we heard reference to the AID's discussions in the early years. We have changed our position on vaccinations because we have identified different causative organisms. We have identified different vaccines as causing more harm than good.

As we begin down this road, we have before us the challenge of a workforce who has already begun to say, we would rather resign and leave because we are not

jeopardizing our health. Keep in mind, we are the ones, as was I, who stand at the bedside when that individual, who is not the majority, responds in an unpredictable way ending up with the symptomology rendering life compromised.

We are the ones who bear witness well beyond statistics because there are no statistics that support our illnesses. We have begun with agreement on the seasonal flu. Our nurses already demonstrating

illness. We have two individuals who are suffering Guillian-Barre like symptoms who have already missed four weeks of work.

In addition to that, we have localized reactions to the injections. We have individuals with swelling of lymph nodes. This is our staff. You won't see that in documentation because there is no record keeping that, in fact, governs the workforce, unless we die, unless we are in a respirator. You do not have a scrupulous attendance policy that even requires us to speak of why we were out for the day.

So to suggest that we know the reactions, we know the influences is simply not correct and, as we go further down the

challenge, we are the same people who are greatly concerned for our health.

Doesn't it seem quite apparent if this was a welcome opportunity, we would jump for it? If we are hesitating, perhaps it indeed suggests that the science has not ensured us that we are safe? That we, in fact, will not compromise our health or our

families? Interestingly enough, if we were doing a public health profile, people don't come before us until they're acutely ill. The rest of New York has no mandate. So there has not been the front line of protection instilled, interestingly enough.

So, as we go forward with the discussions, we want very firmly to support the vaccine and recommend it, but not require it at the expense of compromising health for cause, for cause, documented tangible cause.

In addition, all the vaccination does is of no help if we do not require and offer the education necessary to the public and within the arenas of healthcare institutions, in the homes where our Visiting Nurses will be present.

We feel that the comprehensive approach to the program much demonstrated with the improvements done in the schools is the beginning of understanding the challenge. This is not a quick fix and, by no means, do any of us in the industry feel

safer because of this. But, quite frankly, more resentful and troubled that our state would not understand that, as individuals, we respond differently to different health challenges and, indeed, if an educational program reaches out to deal with the objections, provided they're not health objections, we, in fact, could have worked in a more cohesive environment to succeed at doing what we have entered this profession to do, which is respond in an effective, efficient, and consistent way to healthcare challenges.

So we stand before you knowing there will be many demonstrations, many concerns for cause, and that causes our health because we cannot serve the public if we indeed are not well, and we, indeed, cannot be insured that the opt-out is available for us.

So we are concerned. We support

and see great progress as Chris has reported in the schools, progress. We would have liked the chance not to deplete people's

sick time because of a legal mandate which does not provide for excused paid time in an economy that is grueling and it is quite hurtful.

So these are the points that are before us. I'm quite sure my colleagues will hit upon again, but that is, in effect, an overview of what we think the challenges to be, and I really thank you for the opportunity for sharing that.

CHAIRMAN GOTTFRIED: You mentioned in your testimony, and I think I'm quoting you correctly, that we have learned that some vaccines cause more harm than good.

Can you tell me which vaccines those are?

MS. GOLDMAN: In several situations, the DPT, the pertussis, the whooping cough, many of these vaccines have indeed become optional. France no longer vaccinates for pertussis. We, indeed, have seen --

25 CHAIRMAN GOTTFRIED: I don't mean

to interrupt.

MS. GOLDMAN: I'm sorry.

CHAIRMAN GOTTFRIED: Well, I do mean to interrupt. I apologize for interrupting. You said we have learned that some vaccines cause more harm than good.

The question is not whether France has made them optional. The question is, have we learned -- and I'm not sure who we is, and I'm not sure what learned is, have we learned that the DPT vaccine causes more harm than good?

MS. GOLDMAN: That is, in fact, the current debate. "We," meaning our state, our country, our requirements for children just as we no longer require the small pox vaccination because it caused more harm with the vaccination than it did in eradicating the disease.

CHAIRMAN GOTTFRIED: I think the evidence will show you that we stopped testing -- stopped vaccinating for small pox because it was to all intents and purposes, eradicated from the planet and, therefore,

there was no longer a need to vaccinate for it.

But could you, either now or later, provide us with journal articles or any medical evidence that the DPT vaccine causes more harm than good?

MS. GOLDMAN: We certainly can look at that and the other implication was indeed the flu vaccination, the point being that the flu vaccination that, in fact, we gave did not represent the strain of flu that was infiltrating the city, so, therefore, it, in fact, caused side effects and symptomology, did not eradicate the flu, and was indeed the wrong flu vaccination. That's what I was referring to in that context.

CHAIRMAN GOTTFRIED: When was this?

MS. GOLDMAN: Two years ago. Last year.

CHAIRMAN GOTTFRIED: But is that evidence that that vaccine did more harm than good, or that going into a flu season,

if you have a vaccine that the best evidence is that it vaccinates against the strain that is likely to hit that year, that that's -- that providing that vaccine does more harm than good?

MS. GOLDMAN: The issue was it did not prevent the flu and caused illness in those individuals who suffered side effects including respiratory effects and hospitalization.

CHAIRMAN GOTTFRIED: So retrospectively, because for some reason the strain for which a vaccine was developed, you say turned out not to hit retrospectively you may know that, but does that mean that should our government be -- should the Health Department prohibit people from getting this year's seasonal flu vaccine?

I mean, we do have laws that prohibit people from selling dangerous materials. There are all kinds of drugs that are things that are called drugs that are listed on various schedules. If we see

a manufacturer selling a toaster that will give people electrical shocks, we try to

stop them from doing that.

Is it the position of the UFT that the current flu vaccine should be outlawed in New York State?

MS. GOLDMAN: The position is, and the example was to say that there is not a guarantee that there was efficacy with the vaccination and that it is a calculated judgment which means it should be deferred to the individual to decide based on their personal exposure, their experience, and their health history.

What I was trying to say is, based on the health history and reactions to the vaccinations, that individuals, whether that be flu, pneumonia, DPT, measles or chicken pox, depending on the reaction people have to those, it may or may not be in my best interest to accept that.

The point was to say, while recommendations make good sense and generally are true, when you mandate, you

have done away with the ability of individuals who may have untoward histories of reactions, untoward effects and you're requiring them, by law, to keep their job

and take a vaccination. So the thought process was that.

CHAIRMAN GOTTFRIED: So your belief is that the various flu vaccines do not reduce incidents of flu?

MS. GOLDMAN: I'm not saying that. What I am saying is, depending upon my individual health history, my health risk might be far greater to accept a vaccination than, indeed, to get the flu and run the risk of that, depending on the individual's profile, autoimmune responses, past history of vaccinations, what I'm saying is, you can't mandate from any position other than my personal history, my involvement with my doctor, and my ability to identify what the risks are to me.

You cannot legislate that I would be safer if, indeed, I accepted that vaccine. That's all.

CHAIRMAN GOTTFRIED: So if the regulation provided that if it was the judgment of you and your physician or nurse practitioner that the vaccine is contraindicated medically for you as an individual, does that resolve the problem?

MS. GOLDMAN: It does.

CHAIRMAN GOTTFRIED: Aah. Do you know that the regulation provides exactly that, that if your physician or nurse practitioner says that, for you, the vaccine is medically contraindicated, you are not required to get the vaccine?

MS. GOLDMAN: I do know that, but if I want my job, I need to take it and that's the point.

CHAIRMAN GOTTFRIED: But that's the opposite of what the regulation says. The regulation says that if your physician or nurse practitioner says that for you it is medically contraindicated, the requirement does not apply to you.

MS. GOLDMAN: That's not what's being implemented as we sit before you. We

have many grievances. Individuals taking lawsuits because we have such medical evidence, and indeed the employers and the state have said, it would be professional misconduct to refuse despite that. So we have not had that yet.

CHAIRMAN GOTTFRIED: If can you send me cases of specific cases in which either an employer or the Health Department

is penalizing a healthcare worker in some way who has a medical contraindication statement from that worker's physician or nurse practitioner, that, to me, is explicitly contrary to the regulation. I'd like to see that.

MS. GOLDMAN: That would be very helpful. That certainly is the case. And I think you'll hear more of those examples. That's where the objections come from and that indeed is the case.

As I sit before you today, we have several grievances because employers have disputed and rejected the right of the individual despite medical doctor evidence

to refuse a vaccination and keep their job.

CHAIRMAN GOTTFRIED: And these are, just to be precise, these are workers whose physician or nurse practitioner has written a note saying that for that individual, it is medically contraindicated?

MS. GOLDMAN: That's correct.

CHAIRMAN GOTTFRIED: Well, I'd like to see those instances because that is -- the regulation is about as explicit as can be. That a worker in that circumstance is not required by the regulation to be

vaccinated.

ASSEMBLYWOMAN NOLAN: Are you with the visiting nurse service?

MS. GOLDMAN: We do represent the Visiting Nurse Service.

ASSEMBLYWOMAN NOLAN: But when you're in the Visiting Nurse Service, you're interacting with very sick people all throughout the city, or even someone like myself who just recently had surgery and the Visiting Nurse Service came, wouldn't most of those people, wouldn't you feel that they

should get the flu vaccination because say I was a hip transplant, so hip replacement, so I'd be in a vulnerable state if my health care provider, right, if my visiting nurse gets H1N1, I'm more at risk then, I'm at home recuperating from surgery. So I want my provider to have as many vaccines as -- you know, the most up to date healthcare profile because I'm a patient and I'm vulnerable, right? I mean, isn't --

MS. GOLDMAN: The issue is -- the point is well taken in that we do want people who can to take that. The issue is you have no assurance when someone comes for

your cable TV or anything else, but the point is, yes, we are recommending, but the other side of it is, if I indeed became extremely ill to the vaccination, I could be reassigned in a circumstance where I would not be able to interact with yourself and still keep my job.

ASSEMBLYWOMAN NOLAN: You know, I I came to this -- I really didn't realize the hearing was going to focus this much on

the mandatory issue. I was looking at it from what was happening in the schools because I chair education. I have no brief for the Health Department. They closed two hospitals in Queens, but having said that, if there's a medical opt-out, it seems to me that deals with your issue. And I don't know that I would, just personally listening to the testimony would want to go much further than that, because if you're a sick person in a hospital or you're recuperating at home from surgery, you want your healthcare providers to be, you know, as optimized as possible because you're in a vulnerable position, right? You're the sick person. You're the healthcare provider.

So if there's a medical opt-out,

if have you a preexisting condition that can't tolerate a vaccine, of course, you should have that ability to opt-out. But I don't -- so I don't know what we're talking -- it seems like you already have it, so why are we --

MS. GOLDMAN: The reason this

comes before you, and I'm sure you'll hear it again in a little while, is because the employers' interpretation not only of seasonal but H1N1 is that, in fact, without exception, it is a mandatory requirement of employment resulting in insubordination or termination for those who refuse.

ASSEMBLYWOMAN NOLAN: We have the regulation right here.

MS. GOLDMAN: I do too.

ASSEMBLYWOMAN NOLAN: It says no personnel shall be required to receive an influenza vaccine if the vaccine is medically contraindicated for that individual.

MS. GOLDMAN: The problem is, that's fine. But you don't have to work here is the answer.

The answer to that, and it has

already begun and, again, this is not in a vacuum, and you will hear this and we'll be happy to share with you some of the untoward reactions that have occurred, the employers have implemented disciplinary proceedings

for anyone who, for medical or religious reasons, refuses the vaccine. That's the point and which we have indeed a different opinion.

Again, we are for recommending the vaccine. It is to say that there has to be recognition for individual's health, meaning the worker, who in some instances will be compromised by a mandatory program.

The point after that is the impact it has on one's job if an individual does not comply with the mandation. It has not been clear, as I've been encouraged to hear from you today at all. We have, indeed, have in many calls even supporting those requests before we sat before you today because the employers feel if they don't push this forward without exception, they will not have the benefit of this law.

So the issue, again, is not to go against vaccinations, it is to say there are exceptions to the rule and that

sometimes comes in the form of the workforce who cannot put their health at risk because

of a mandation, although you've assured me that is not the intent of the law and that is extremely helpful. We do have discipline before us on this issue.

So we'll look forward to giving you that information and hopefully succeeding at not having discipline impact those who have made those refusals for medical reasons.

CHAIRMAN GOTTFRIED: Labor law is not my field of specialty, so I can't comment on whether an employer in a given circumstance on their own motion could or cold not impose a requirement like this on workers having nothing to do with what the Health Department says.

However, it is, to me, as clear as can be and I don't know how you would write a regulation any clearer that this regulation quite explicitly does not require a worker to be required to be vaccinated in any circumstance where that worker's physician or nurse practitioner found that it would be medically contraindicated for

that workers.

I can't imagine that there is any well-educated reading the regulation who would need my advice to -- or my assistance to discover that in the regulation. It's about as clear as I can imagine it being. There are things sometimes that are ambiguous, this is not, in the slightest.

MS. GOLDMAN: I would just say to that, we have contracts that seem quite clear when we negotiate them, we have hundreds of grievances all year long.

CHAIRMAN GOTTFRIED: We have laws that say people shall not do some things and they go ahead and do them anyway, but the regulation very clearly is not the source.

If that is a problem, the regulation on its face is very clearly not any authority for that kind of problem, okay?

MS. GOLDMAN: Thank you.

CHAIRMAN GOTTFRIED: Thank you. Any other questions?

(No verbal response.)

NYSA/10-13-09 H1N1 Influenza

Okay. Our next witness is Doris Dodson from the Public Employees Federation.

(The witnesses were sworn.)

MS. DODSON: Good afternoon.

My name is Doris Dodson. I am the Public Employees Federation's Statewide Nurses Committee Chair and the Long Island Region 12 Coordinator for PEF.

I work as a registered professional nurse for 20 years. I have with me my counterpart, Jenna Hanson, from Brooklyn, Queens, and Staten Island, and I also have Colleen Heinsy, a registered nurse in my union's sister from Stonybrook Hospital, whose comments I believe will give you more insight into critically thinking people don't voluntarily get vaccinations.

New York State PEF represents 59,000 professional, scientific and technical employees including over 15,000 healthcare professionals, 9,000 of which are registered nurses who work in a variety of state agencies. We are partners throughout the healthcare system. We have not been

included in preparedness planning.

PEF is very concerned about the current H1N1 pandemic. To date, the impact on state agency healthcare has been minimal, however, please take note in the event that a more fatal virus emerges, we find that there is a lack of preparedness at the state, county, local, and employer levels. In New York State, preparedness starts with the leadership of the State Health Department.

The Department of Health should reach out to unions that represent healthcare workers, professional organizations, healthcare employers, as well as county and local health and emergency preparedness officials to develop a broad coalition on influenza and pandemic preparedness. This non-coercive inclusive approach is the most effective way to prepare stakeholders to act in the event of a true emergency.

Union representatives who work in healthcare facilities can directly address

the issues of hospital preparedness from the point of view of the direct care workers.

Our written testimony lists the

issues that PEF has identified as needing immediate attention. A major concern is the lack of influenza exposure control plans to protect the occupational health of staff and prevent disease transmission among patients and visitors. The exposure control plan should be written and available for review.

It should begin with an assessment of the risk to exposure that employees may encounter at their workplace. It should detail the engineering and work practice controls.

For example, what labels and signs should be prepared and posted? What personal protective equipment is in house and available? What respiratory protection program and equipment is in place?

Providing employees with information and training should have been done already and it hasn't been. And vaccinations should be voluntary, not

mandated.

To improve participation, these vaccinations should be provided at no cost to any employees who will potentially be exposed as a part of their job and done at a

time and place that is convenient for the employees. Our recommended control exposure plan includes post-exposure follow-up and record keeping.

The New York State Department of Health should adopt federal CDC, OSHA, and IOM guidelines on respiratory protection. A number of peer reviewed studies have documented that influenza is transmitted through contact droplets and airborne routes. The quantity of infections that are attributable to the airborne route is not known.

The CDC and OSHA and a panel of experts commissioned by the Institute of Medicine have recommended the minimal use of fit-tested N95 respirators for providing care for suspect or known cases of H1N1.

N95s provide a tight seal around

the nose and mouth, and the material they're made out of is designed to filter out sub-micron particles. If you've seen surgical masks, they fit loosely, they're open on the sides. If somebody sneezes at me, particles and droplets are going to float right around that surgical mask into my airway.

Surgical masks, which is all that is which is all that is being made available in some situations do not provide a facial seal and do not filter out infectious particles. The Department of Health is defying the Federal recommendations and, instead, has issued guidelines to facilities that a surgical mask is adequate protection for routine care of suspect or known cases.

This has caused a delay in healthcare employers obtaining the necessary equipment and the welfare of our healthcare employees is being jeopardized.

On August 24, 2009, the New York State Department of Labor's Public Employee Safety and Health Program, better known as

PESH, issued a staff directive entitled, Enforcement Procedures and Scheduling For Occupational Exposure to H1N1 Influenza. It adopts the OSHA, CDC, and IOM recommendations for respiratory protection. This preferred position protects patients and healthcare workers alike.

We applaud the Department of Labor for its leadership in this realm, however, now we have two sister agencies

making contrary recommendations to the regulated community. This dilemma must be put to rest by mandating the appropriate worker protection outlined in the Department of Labor enforcement guidelines.

On August 13, 2009, the Commissioner of Health enacted an emergency regulation mandating that certain healthcare workers be vaccinated with seasonal and H1N1 vaccines, or face loss of their jobs. This is bad public policy.

The commissioner inexplicably bypassed the New York State Legislature in taking this action. Further, he bypassed

the normal public input requirements of the State Administrative Procedures Act. The Commissioner did not recognize the need to work cooperatively with healthcare workers, unions, professional organizations or employers.

The Commissioner was not justified in taking this drastic action. Neither the federal government nor any other state in our country has taken such similar action. The emergency regulation was not warranted in that there is not an emergency situation. The regulation is inequitable in

that it targets one fraction of five priority groups identified by the CDC for H1N1 vaccination.

PESH urges the Legislature to voice very strong objections to Department of Health's emergency regulation. This mandate doesn't recognize that the affected healthcare workers have the right to exercise informed consent in deciding whether or not to be vaccinated.

Using this coercive measure has

alienated the very frontline healthcare workers who will be called up to respond to a true influenza crisis.

So now we have an emotionally charged work environment that pits management against subordinates and coworkers against coworkers where people are working under duress and stressed out with worry over losing their licenses and their livelihood.

In summary, instead of mandatory vaccination, PEF supports these actions: Bring all the stakeholders together and work to develop a comprehensive approach to preparedness that includes a massive

campaign to increase health care,
participation and public vaccination rates;
a comprehensive influenza exposure control
plan that guess beyond vaccination; adoption
of federal guidelines for respiratory
protection to prevent the spread of the
disease, including the use of N95
respirators where appropriate; and education
of healthcare workers to encourage voluntary

vaccination.

I would like to turn this over to Colleen who has some additional comments that she has collected from bedside workers.

MS. HEINSY: Thank you for the opportunity to present this information to you. I was not expecting to speak today. I left work at 7:00 this morning and hopped on a train and haven't been to bed in quite a very long time. But my coworkers really encouraged me to come in because the first thing they wanted me to tell you is that, there is just one nurse sitting here, but I represent well over 100 nurses that I spoke to last night alone back at the hospital. I want you to know that this is very important to them and not something that they're taking lightly, it's not just a reaction to

the mandation, but that they are educated, intelligent people who believe they're making an informed decision about their vaccination status, and feel like their rights have been violated by having that decision-making process taken away from

them.

Some of the concerns that a lot people have would be the ingredients contained within the vaccine. First of all, the nasal spray is a live virus, which I know many people cannot get because of their asthma and respiratory status, but most of the hospitals will be receiving multi-dose vials, not individual dose vials, and those vials, most of them contain aluminum, mercury, are squalene. There are a lot of concerns over the suspended mercury testing, so there's not any way to really know how much we're getting in any vaccine, and squalene has significant concerns as well. Some studies have been linking it to Gulf War Syndrome and I believe it still lacks the FDA approval.

We really want to make sure that we put out that we respect the DOH, and we

understand that they've taken on a huge responsibility for the public health and safety, and we appreciate the task that they've undertaken, and we would just ask

that they respect us as well as educated individuals who are trying to make informed decisions about our own bodies and our own health.

We love our jobs. We love our patients. We want to provide them with the best care possible and we want to do that without sacrificing our rights as individuals to provide them that care.

The last thing I would like to say is that they would really -- my coworkers and I, we would all really like you to reconsider talking to the DOH and the powers that be. We would like this to be reversed. Many people are not objectionable to take the regular flu vaccine, but the fact that it's lumped in with the H1N1 with which people have many more concerns is a problem, and they would feel like they would not have an issue taking the regular flu vaccine, though they feel it should be optional. But that including the H1N1 in there with its safety concerns still puts

them at risk for losing their jobs and

they're honestly terrified of that. I know many people who are already looking at securing an additional job so that if come December 1st, they're fired, they will have some way to support their families and pay their mortgages.

So thank you very much, again, for listening and we do appreciate you take the time to hear us.

CHAIRMAN GOTTFRIED: Several questions. In a workplace where there were PESH regulations which requires the offering of an N95 mask, is there any reason to believe that that requirement is undermined by the lack of a Health Department requirement to do the same, do you know? I'm asking the people who are testifying. If you're testifying later, I can ask you that. But, for now, I'm asking these folks.

MS. DODSON: We've had reports from one of our hospitals that management is following the mandate from the Department of Health and the recommendation that surgical masks are all that's required and denying

availability to the N95.

MS. HANSON: And, actually, the meeting that we had with the commissioner, Commissioner Daines, had a nurse there from Buffalo that said initially, when they had an outbreak in Buffalo, they used the N95s and then, because it was being used too readily, they pulled it back and started to use the regular surgical masks and nurses started to get ill.

So there was an issue with them pulling back the regulations at that time and it was a big concern to that particular nurse that worked in that institution.

CHAIRMAN GOTTFRIED: Okay. I have a couple of questions about the vaccine and the nurse who testified. I'm sorry, I didn't get your name.

MS. HEINSY: I'm sorry, my name is Colleen Heinsy.

CHAIRMAN GOTTFRIED: On the question of whether you should have a right to informed consent for that vaccination, apart from people's feelings about it, and

I'm not denying the significance of feelings, is there a medical or scientific difference between the mandate for a measles and rubella vaccination and a TB test, versus the mandate for a flu vaccine?

MS. HEINSY: We would say yes. Several of the points being is that -- first of all, the measles, mumps, and rubella, most us received that when we were children. We did not have a say whether or not that was given to us.

CHAIRMAN GOTTFRIED: Excuse me. But in order to be a healthcare worker in this state --

MS. HEINSY: We're required a titer to be drawn to be see if you still maintain immunity.

CHAIRMAN GOTTFRIED: And, if not, you are then required to have the vaccine?

MS. HEINSY: With some exceptions to that as well, and there are instances in which you can decline.

CHAIRMAN GOTTFRIED: Such as?

MS. HEINSY: But also, you can --

for health reasons, religious reasons.

CHAIRMAN GOTTFRIED: There is no religious exemption for the measles vaccine requirement.

MS. HEINSY: For people that are now against vaccinations in general in their religious state, there is --

CHAIRMAN GOTTFRIED: No. For the school vaccination requirements, there is a religious opt-out. For healthcare workers, there is a medical opt-out for both flu and measles. There is no religious opt-out for either one.

MS. HEINSY: Then I was misinformed about the MMR. I was under the impression that you were allowed -- depending upon your religious standpoint, if you did not receive vaccines in general in your religion, to not be boostered for the MMR, whether you received it initially, I don't know, my understanding is that you did not have to receive a booster.

CHAIRMAN GOTTFRIED: Well, there may be individual employers who are looking

the other way, but the regulation does not include any religious opt-out.

MS. HEINSY: But our main difference between the MMR is that you can

-- is that it is regulated, it's better tested, and in the current H1N1 vaccine, the mercury testing has been suspended, and the other ingredients in the vaccine itself are concerning to many nurses. So it's not -- it's more of a health question than it is a simple thing of being mandated to do it.

CHAIRMAN GOTTFRIED: During the lunch break, I consumed about 15 percent more mercury then I will get when I get my flu shot. My bet is that in a given week there's a fair proportion of the people who object to the flu shot who have a tuna sandwich.

MS. HEINSY: But there's no way to know because the testing has been suspended and it's not the only ingredient that people have objection to.

CHAIRMAN GOTTFRIED: When you say the testing was suspended --

MS. HEINSY: The limit testing of mercury in order to turn more vaccine out in a quicker fashion and create a larger supply, they decided to suspend the limit testing for the amount of mercury within the vaccines.

CHAIRMAN GOTTFRIED: Would it be more accurate to say there was extensive scientific review back and forth about the question of mercury in vaccines that concluded that it had no negative health consequences and that's why people aren't studying that anymore?

MS. HEINSY: There's plenty of arguments on both sides. There may be a study that says that, but there are many studies on the other side of that. So it depends on what study you decide to read and hold to your own.

CHAIRMAN GOTTFRIED: Well, there are also people who have done systematic reviews and found that there is an answer. You made reference to squalene. It is my understanding that squalene and other

adjuvants are not used in the flu vaccine.

If that is true, does that take squalene off the list of issues in the flu vaccine area?

MS. HEINSY: My understanding is that it is part of the H1N1. When we were given a list of the ingredients, squalene was on the list of the ingredients of the H1N1 vaccine.

CHAIRMAN GOTTFRIED: But if it's not, would that take that off the list of concerns?

MS. HEINSY: Well, if there's no squalene, then we wouldn't be objecting to squalene.

CHAIRMAN GOTTFRIED: Exactly.

MS. HEINSY: I mean -- yes.

CHAIRMAN GOTTFRIED: That's kind of my point.

MS. HEINSY: Yeah, then definitely take that off. If there was no squalene, we would not be objectionable to taking squalene.

CHAIRMAN GOTTFRIED: This year's

seasonal flu vaccine, which you said includes three strains of flu. In what way is the H1N1 vaccine scientifically or clinically different simply because this H1N1 strain is a different strain from the H1N1 strain that is among the three in the seasonal flu shot? What is there that is different?

MS. HEINSY: If we go back to the testing of the vaccine, and the suspended mercury limits, suspended squalene, and the

rapid way in which it was rolled out -- and I know people said that there's been much testing done on it and more testing on this then on the regular. I heard some testimony mentioned earlier, some of that testing --

CHAIRMAN GOTTFRIED: Excuse me, do you think that the people who say it has been more tested than the seasonal flu vaccine is tested each year are just mistaken or lying?

MS. HEINSY: No. That's simply what they said.

CHAIRMAN GOTTFRIED: Do you think

that's true, or do you have an opinion on that?

MS. HEINSY: I have no position to doubt the integrity of another person. All I can speak to is my personal integrity, which, to me, is the most important thing in my life.

CHAIRMAN GOTTFRIED: But why would one -- is there a clinical or scientific evidence that you're aware of as to why the so called swine flu vaccine is materially different, meaning different in a way that matters --

MS. HEINSY: It has --

CHAIRMAN GOTTFRIED: -- from the three strains in the seasonal flu shot?

MS. HEINSY: We're not talking about the actual swine flu. We're talking about the components within the vaccine itself.

Once again, I'm speaking on behalf of not just my own concerns, but I'm trying to bring in concerns that have been voiced by hundreds of people, which is kind

of hard to do.

So it's not that we're just objecting to H1N1, it's the components in the H1N1 vaccine which are not contained in the regular flu vaccine.

CHAIRMAN GOTTFRIED: Other than the question of whether it does or doesn't contain squalene and maybe a later witness can clarify that for us, is there any other difference?

MS. HEINSY: I'm sure there are, but I am not an expert on the components of the vaccine. I simply got lists that told me what were in each and did my own research on the side effects and cause and effect of those ingredients.

CHAIRMAN GOTTFRIED: Okay. And considering the roughly 36,000 people who die each year from flu, compared with what we know of the rather infinitesimal number of cases of bad reactions to flu vaccines, is there a basis for concluding that there is somehow -- that it is more dangerous for a healthcare worker to take the flu vaccine

than not to?

MS. HEINSY: I don't think anybody has said that it's more dangerous. Simply, that the danger should be ours to choose to take. That right has been taken away from us. And that's where our entire basis of concern comes from, is that we don't have the right to choose whether or not we take it on that risk.

So either we choose to take on the risk of a vaccine, which may be infinitesimal, or we choose to take on the risk of the actual flu itself. Either way we choose to take a risk.

But right now that choice has been taken out of our hands and we're being told, you must take this risk or lose your job, and your livelihood -- people are talking about picking up and moving out of

state, having to uproot their children, not being able to pay their mortgages anymore. These are huge concerns for families and our whole point is that it's no longer been our decision but that decision's been taken out

of our hands.

CHAIRMAN GOTTFRIED: Is it relevant to that point that the right you are asserting is the right to potentially infect medically compromised patients who are in your care? Is that relevant?

MS. HEINSY: We would say two things to that. One, does another's rights outweigh my own as an individual? So when does one person's rights become more important than another's?

The other statement being, you're assuming, A, I'm going to get the swine flu, and, B, that I'm going to come to work and give it to somebody.

So those are two huge future assumptions which have not yet occurred so I cannot speak to whether or not I will give swine flu to a patient because I do not have swine flu.

CHAIRMAN GOTTFRIED: The vast

majority of people who exercise their personal choice to drive home drunk get their safely.

MS. HANSON: That's unfair.

CHAIRMAN GOTTFRIED: The vast majority of people who drive drunk get home safely. Most of think, probably all of us think that their right to drive drunk is less than my right not to be a victim of their drunk driving. Even though, the vast majority of times when they drive down the road drunk, they will not cause an accident.

So the fact that a given healthcare worker who is vaccinated might not have gotten the flu, or might not have spread it to scores, or exposed scores or hundreds of patients, to me, does not answer the question.

MS. HEINSY: But your comparison would be like me saying, not only am I not going to get the swine flu vaccine, but I'm going to carry contaminated blankets and put them onto my patients.

CHAIRMAN GOTTFRIED: No. You don't have to carry contaminated blankets --

MS. HEINSY: You're choosing to drink. You're choosing to put into your

body an element that's going to compromise you. I'm not choosing to carry swine flu around with me and pass it around.

CHAIRMAN GOTTFRIED: Right. You're not choosing, but it happens -- it will happen to many of your colleagues whether they choose to or not, and whether they know that they're carrying the influenza or not, that's the problem.

If we were talking about nurses who were choosing to get swine flu, then that would be very different. We're not talking about coming down with a disease where that's a choice, are we?

MS. HEINSY: It's not a choice to get it --

CHAIRMAN GOTTFRIED: Right.

MS. HEINSY: But it is a choice to come to work sick. It is a choice to come to work and spread that disease to your patients. We have personal protective equipment. We have hand-washing policies. We have sanitizer on all the walls. We have face masks and gowns and gloves. We have

isolation rooms for patients that are ill. We practice policies so as not to spread disease to each other on a daily basis, whether we have swine flu or not.

I practice that I not spread my cold to patients. I practice that I not spread whatever else I may be carrying to my patients. So if I happen to be carrying the swine flu vaccine, why is that more of a problem to -- why would that be more of a problem to spread to my patients than the cold? How am I more likely to give that to them practicing my personal protective equipment and policies of infection containment than with the swine flu?

MS. HANSON: Can I also speak to that? As a healthcare professional, this work -- as a ground level registered nurse for over 20 years that has never had the seasonal flu, and has been blessed with the institution that saw the wisdom of following the CDC guidelines and using masks and using protective equipment.

I've had patients who have had

the flu. I've never had the flu. I've never spread the flu. Because we don't come in as registered nurses and professionals to hurt patients. We come in to do the best that we can. And at a time where we should be coalescing, mobilizing our healthcare professionals to do the best job possible, with the instruments that they need to do so, we're not doing that. We are sending them away. We're telling them to go home because they won't take a vaccine.

I'm not the only health professional that has worked a lifetime and hasn't been mandated to take a flu shot and hasn't taken a flu shot in the past, and has worked safely, has worked competently with my patients.

There's other healthcare professionals out there that has done the same thing. There is no studies that are out there currently that links being a hospital worker with passing on the flu. I have yet to see it. I think our professionals have searched for it. Where

has actually given their patient. Maybe in nursing homes, maybe, but we haven't seen it in the literature where that has come to fruition.

We want to work safely, but we also want to have the right to say what goes into our bodies. We're human beings. We want to be treated as human beings and not be mandated to take a vaccine that we may not feel is the best thing for us, especially if it's related to our own health and well being.

Many of our nurses, as it was said before, are older professionals. We're not spring chickens. We're not young people. We're older, and we have concerns, health concerns.

We have worked safely in the past and we will continue to work safely because we don't just use one mode. We use a comprehensive program of ensuring that our patients are safe when we work with them in

our environment. And we will continue to do that as healthcare professionals.

We're just saying this is not the time on the cusp of a pandemic to be mandating vaccines and driving healthcare

workers out of the place where they're needed the most and that's at the bedside.

ASSEMBLYWOMAN NOLAN: Dick, I have to go. But I just want to thank, particularly the last speaker, it was very eye-opening. It's been very eye-opening the whole hearing, and I appreciate your coming in from Stony Brook.

I don't know that I completely agree. I came at the hearing from some different points being from the Education Committee and looking at it as a parent and how the city was responding, but it's been very a very illuminating hearing and I look forward, Assemblyman Gottfried, to talking with you, and my colleagues Deborah and Assemblyman Lancman. I want to thank you, Rory, for getting your subcommittee off to a roaring start and talking about safety in

the workplace, very important.

So, I apologize, I have to go, and I've been coughing the whole time anyway, but I have to pick up my own son. And I just think we do have to keep in mind at all times that, you know, they don't have to be competing interests, I agree with you,

the interest of my child at a public school, and my sister's, who is a nurse, for example, shouldn't have to be competing interests. But that being said, I'd like to reserve judgment on what the Health Department did. I don't know that I oppose it. I know many of you do. And I apologize that I can't hear all the testimony, but I will read it online and continue to dialogue.

Thanks very much.

MS. HANSON: Thank you. Can I make one other comment? That is, there's no uniformity. We have healthcare facilities upstate, around the state, that are next door. We have Albany Med that's mandated to take the vaccine, and then we have other

facilities right next door like our psych centers that are not mandated. And they constantly go -- these healthcare professionals that are not mandated constantly go into the hospital and out of the hospital, as well as our emergency responders. Not all of them take the vaccines, and they come in and out of our hospitals with patients every day. There's no uniformity in this mandation, and that's

not a correct way to bring forth a public health policy.

CHAIRMAN GOTTFRIED: By the way, some of that may to have to do with the scope of the regulatory authority of the Health Department.

MS. HANSON: But shouldn't there be collaboration?

CHAIRMAN GOTTFRIED: There certainly should, but that doesn't mean that the Health Department can invent statutory authority simply by collaborating. And I would certainly agree -- I mean, I would hope it goes without saying, that it is

clear that healthcare workers do not come to work meaning to harm their patients, healthcare workers come to work precisely to protect their patients. I can't imagine anyone suggesting the contrary, certainly not me.

And I also think it is pretty clear, and I hope it is clear to the Health Department, that what has gone on around this regulation and other issues relating to flu preparedness, demonstrate once again the proposition which really doesn't need to be

demonstrated but apparently always does, that it's always a lot smarter and produces better outcomes if you talk to the affected people beforehand and work with them, and, clearly, the Health Department did not do that.

The out cry I think is magnified probably at least 10 fold as a result of that. Hopefully they will learn that lesson and remember it, at least for a while, until they have to learn it all over again.

I sometimes think all of us in

elected office could probably go out and earn a living giving that advice to any number of people. So I think that message comes across loud and clear here.

And that all of you who are here today saying that there is a serious lack of working with the representatives of working people, has been a major failing here, and had it been done otherwise, not only would people be a lot whole lot calmer, but I think we would have a much better program of preparedness. I don't think there's any doubt about that.

ASSEMBLYWOMAN GLICK: First of all, let me thank you for your testimony. I

think you spoke very eloquently, and I think with whatever little sleep you've had, you held you held your own heard. Maybe you can sleep on the train going back.

Let me say that I don't know where I am on some of the issues that have been raised.

I think that, particularly, nursing has been a profession dominated by

women. I think medical testing of drugs have generally until relatively recent memory, was almost never tested on women.

The information that has come out over the years about hormone replacement therapy is the sort of thing that raises concerns, and I think that you make a compelling argument for at least wanting to know precisely what it is you're putting in your body.

I think that that's, you know, a struggle that we're all having when we look at what, you know, the FDA has not done over the last eight years, and how that's been dismantled. I'm afraid to eat. I commend the assembly member for having a tuna fish sandwich. I myself never eat fish and feel

that I've made a wise decision.

CHAIRMAN GOTTFRIED: And you eat meat and I don't.

ASSEMBLYWOMAN GLICK: Actually, I eat very little. I never eat red meat. But now we know too much about my dietary habits.

The reality is that I think that we're all concerned about what kind of hormones are in food, what kind of antibiotics are in food, what kind -- all of the things that perhaps give rise to a whole host of health concerns that people have including the concern that people have about not being able to reproduce is sort of an interesting thing that's happened and should be a warning to all of us.

So I respect tremendously the concerns that have been raised. I also know that the flip side of it is that, you know, I never want to go to a hospital unless I'm brought there unconscious because that's a choice that I don't make willingly because of staph infections and the rest of it.

So as I said to people in the higher ed world, it's great that you're all on board and that you're putting up these

signs, but this is an emergency, what's been the situation that you've been dealing with over the years where, you know, kids regularly -- staph -- strep, rather, just

runs rampant and there isn't this same level of concern.

So I think it should be a wake-up call across the board. And where, you know, I'll be honest with you, my doctor says to me, you're exposed to the public all the time, wash your hands 17 times a day, and you better take a flu shot. I take the flu shot. That's a discussion I have with my doctor, and I have over the last few years, and, knock wood, it's been an effective thing.

And I am not exposed to all of the things that you all are by working in a hospital. That is, by its definition, an incubator, a pitre dish.

So I don't know where I am on the larger question, but I do respect and understand your concern about wanting to make choices about what you have put in your bodies.

But thank you for your very

eloquent delineation of how careful health professionals are with a host of protective

devices and strategies.

Thank you.

CHAIRMAN GOTTFRIED: And for the benefit of the stenographer, I think when you said staph infections, you were spelling that with a p-h.

ASSEMBLYWOMAN GLICK: So far.

ASSEMBLYMAN LANCMAN: I, too, want to thank you for your testimony and I'm just disappointed that Commissioner Daines was not here to listen to it, because I think if he did, he would see that the people who have concerns about the mandatory vaccination are not self-interested, uninformed people, but people who have really given a lot of thought to this issue.

I just want to add or bring back to the conversation the issue of the different guideline on the N95 respirators between the Department of Health and the CDC and the Department of Labor, and just to say that, this is a very complex issue. It's a very fluid issue.

I think that at the very least,

we should have an expectation that our different government agencies are going to, themselves, get together and try to be on the same page. And I'm sure it's the case that -- I'm sure it's the case that hospitals and other healthcare employers, like all employers, just institutionally, will seek to follow the path of least difficulty and least resistance and if there is some guideline out there that will make it easier for them to justify doing less, to justify not providing the N95 respirators, I know that's what they're going to do, and it sounds like that's what your experience has been.

So, again, I just strongly urge the Department of Health to get on board to coordinate with the CDC, to, you know, come up with a guideline on the respirator issue that is uniform so that workers and employees can go to their employers with an expectation of getting the maximum assistance, maximum safety precautions possible and not what we have now with

different interpretations and different guidelines which allows the employers who chose to do the least amount to protect the safety of their employees as possible.

And with that, I just really wanted to thank you again for your testimony.

CHAIRMAN GOTTFRIED: I concur. Thank you.

MS. HAINSY: Thank you.

CHAIRMAN GOTTFRIED: Next is the New York State Nurses Association.

(The witnesses were sworn.)

MS. GRECSEDI: Good afternoon. Thank you. I first want to thank Assemblyman Gottfried, and Lancman, and Assemblywoman Glick for this opportunity. My name is Renee Grescedi and I'm program Director For Nursing Education Practice and Research of the New York State Nurses Association.

With me for help in responding to questions is Tom Lowe, and he is our occupational safety and health

representative. We are both practicing RNs.

The New York State Nurses Association is the larges professional association and union for registered nurses in the Empire State. We have more than 37,000 members in a range of practice settings, from public schools to nursing homes; from hospitals to correctional facilities; from home care to academia.

Regardless of their practice specialties, our members were concerned about the appearance of a novel flu strain last spring. As the epicenter of the outbreak was New York City, nurses wanted to be informed about the spread of the virus, its symptoms, and how to treat infected patients.

Many of our members asked us what should be done to prevent the spread of infection as no vaccine was available at time. We advised them that the patients with confirmed or suspected H1N1 influenza should be kept in isolation, and those caring for them should use fit tested N95

respirators in addition to standard infection control protocols, such as hand washing.

This advice was based on recommendations by the Center for Disease Control and Prevention, the CDC. The Occupational Safety and Health Administration requires healthcare employers to identify hazards in their facilities, assess the risk to employees from these hazards, and develop a plan for removing or reducing them.

As more research became available on how the H1N1 virus is spread, the airborne mode of transmission was identified as one of the means of spreading the virus. This mode of transmission warrants the use of a fit tested N95 respirator or better.

It soon became apparent, however, that many healthcare facilities had not done risk assessments nor kept current with evolving scientific studies which documented the airborne mode of transmission as a contributing factor to the spread of the

virus. Furthermore, they did not have enough N95 respirators.

A recently released survey of 190 American hospitals found that 15 percent did not have respirators available, and more than 25 percent had inadequate or no

engineering controls to isolate H1N1 flu patients.

Hospitals in New York told their employees that a surgical mask was sufficient protection while caring for flu patients. This view was supported by guidelines issued by the New York State Department of Health.

A study sponsored by the CDC has confirmed that the N95 respirator is the minimum level of protection for healthcare providers as H1N1 can be transmitted via aerosolized particles that are not blocked by surgical masks. The Department of Health, however, has continued to advise hospitals that surgical masks are acceptable protection.

During the last nine months, the

Nurses Association has been concerned about the lack of broad, coordinated plan for dealing with an influenza pandemic. The Commissioner of Health did not declare a public health emergency based on the threat of H1N1 influenza. This would have given him broad powers to require vaccinations, set up containment or quarantine areas or

other measures outside the usual reach of government regulation.

This brings me to the issue of mandatory vaccination for healthcare workers. This requirement was put forward as an emergency regulation at the June meeting of the State Hospital Planning and Review Council and was in effect by mid August. There was no opportunity for comment or public review. The Nurses Association did present testimony in July, but was the only organization that was able to do so within the brief timeframe.

Oddly enough, the initial version of the emergency regulation did not refer to the H1N1 influenza. It mentions only

immunization for the seasonal flu. It is unclear why this year's seasonal flu precipitated an emergency regulation. It was in the revised regulation after verbal conversations that Commissioner Daines added that it was the intent of the regulation to include the H1N1 vaccine should it become available.

In fact, the state is sending mixed messages about the impact of H1N1. On one hand, the threat to public health is not

great enough to close schools, force employers to provide sick pay or mandate vaccinations for the entire population.

On the other hand, the threat is such that healthcare personnel must be either immunized or lose their livelihood and careers. To make a mandatory vaccination program at the end of the contagion continuum, in the hospital rather than in the community where the flu originates, is not the most effective public health measure to control the spread of the virus, and does not deploy limited

quantities of vaccine where the greater good could be served.

State officials have commented that healthcare personnel who refuse or object to being vaccinated don't care about their patients safety. This is insulting to nurses in an effort to divert attention from the real issue, do mandatory vaccination programs make patients any safer than effective voluntary programs?

Voluntary programs have increased acceptance rates within individual facilities up to about 80 percent, but I

must explain that these programs involve more than putting a poster on the wall and putting brochures on a table. They require commitment of time and resources, education, incentives and convenience. But they do not get employee buy-in from year to year.

The State's decision to mandate vaccinations may have an unintended negative effect. As vaccinations are not widely available to the public, the surge in influenza cases is likely to tax healthcare

facilities that already are short staffed.

A number of major hospitals have notified their employees that if they refuse to be vaccinated, they will first be put on unpaid leave and then fired. It makes no sense to remove qualified healthcare personnel from the workforce just when they are needed most.

Patient safety cannot be guaranteed by programs that rely solely on vaccinations to prevent the spread of influenza. Unlike polio, small pox or hepatitis, the flu virus is constantly mutating.

In some years, the vaccine has been less than 40 percent effective.

Vaccinations must be considered part of a comprehensive infection control program that will benefit both healthcare personnel and their patients.

To help meet the goal of preventing hospital-acquired influenza, the Nurses Association proposes that the state withdraw the regulation requiring healthcare

personnel to receive flu vaccinations, create a task force of stakeholders to assist in the development of a more effective, comprehensive approach to preventing the spread of influenza, revise the Department of Health guidelines on respiratory protection for workers to more clearly state the need for a hazard assessment when selecting the proper level of protection, and establish the N95 respirator as the minimum level of protection for direct care of patients, residents, and clients who are suspected or confirmed to have an infectious respiratory illness.

Thank you for this opportunity to address the assembly.

CHAIRMAN GOTTFRIED: Maybe you

can educate me a little. Maybe the term is a misnomer. Is a surgical mask, what we've been calling a surgical mask, is that, in fact, what people in an operating room wear, or is that a misnomer?

MR. LOWE: No. There's a

surgical mask that the folks in the operating room wear, and there's also a surgical N95 mask that can be worn. The surgical masks are designed to keep large particles and droplets inside -- and contain it inside the mask. It's to take the infected person and kind of put a barrier up between them and the environment.

The N95 is for the protection of the worker. It filters out the small particles that the infected person gets out into the air transmitted over to the healthcare worker.

CHAIRMAN GOTTFRIED: Why is a surgical mask, plain, ordinary surgical mask sufficient to protect a surgery patient who is, you know, whose insides are wide open, from what comes out of the mouth and nose of operating room personnel, including the surgeon, I mean they presumably are equally porous one way or the other, why is that a

sufficient barrier to protect a surgery patient from the ordinary stuff that comes out when we breathe, or when a person in the

operating room might cough, but not a good enough barrier to protect the healthcare workers when they are inhaling when near an infected patient?

MR. LOWE: Okay. It has to do with the design and composition of how the two are created. The surgical mask is designed to catch vapors and large particles coming out of the healthcare professional's mouth and trap them on the mask itself.

CHAIRMAN GOTTFRIED: Right.

MR. LOWE: When a person coughs or sneezes, you've got large particles and, as they go out through the air, some of the water and the fluid around them starts to fall off and you're left with a small infectious particle.

The surgical masks are designed to catch that large droplet as its coming out of the mouth of the individual that's wearing the surgical mask.

The N95 is designed to be on the receiving end of the small particles that

come at the healthcare professional and are

designed to protect the healthcare professional.

CHAIRMAN GOTTFRIED: So what you're saying is, at the point where the particle comes out of someone's mouth or nose, it is large enough to be trapped by a surgical mask, but when it has come out of someone else's mouth and then travel through the air for a while, because of evaporation or what have you, it becomes a smaller particle and, therefore, to protect it from being inhaled, you need the N95?

MR. LOWE: That's correct. That's what the recent studies now are beginning to show.

CHAIRMAN GOTTFRIED: Okay.

MR. LOWE: And that's why we put a surgical mask on the patient to help shield the patient who is coughing and sneezing from the environment and the healthcare professional should be wearing the N95.

CHAIRMAN GOTTFRIED: Okay. No -- I mean, I certainly understand that the

surgical mask does not protect against the smaller particles, what I was not understanding was how the particles that you might be breathing in would be smaller than the particles that you might be breathing out and you've explained that.

MR. LOWE: The other component to the surgical masks in the operating room is the air flow in the operating room is specifically designed to be pulled away from the patient and the surgical site. There are what they call gas scavengers that some surgeons use and they actually draw the particles away from the surgical site as another mode of infection prevention.

And that points to -- just focusing on the respirator or the surgical mask, is equally wrong as just focusing on the vaccine as a prevention. The emphasis has to be on a total infection prevention program.

CHAIRMAN GOTTFRIED: Thank you. Questions?

ASSEMBLYMAN LANCMAN: I asked

this before of Joel Shufro before, but do you know what the commissioner was referring to when he said that he was expecting the CDC to come out next week with new N95 respirator guidelines which, I infer from the way he said it, were going to agree with the New York State Department of Health's guidelines.

Do you know what he was talking about?

MR. LOWE: Yes. The Institute of Medicine did that study and came out and recommended that the N95 or better is the minimal acceptable respirator for healthcare professionals to be protected against the H1N1 influenza virus. And the decision was made without consideration for cost, without consideration for supply, without consideration for any of the other factors that would go into the availability of the N95.

What the CDC is considering and, this is what we're hearing on the government labor calls and the CDC on a weekly basis,

is they're considering the factors that the IOM specifically did not consider, and

that's the availability, the cost factor, supply and demand.

They're not -- let me not say that. They're looking at the factors other than the scientific pure data.

ASSEMBLYMAN LANCMAN: So the CDC is getting ready to cave based on these other considerations outside of what is absolutely the most appropriate for a safe workplace?

MR. LOWE: We believe that that may be a possibility.

ASSEMBLYMAN LANCMAN: Thank you.

CHAIRMAN GOTTFRIED: Thank you very much.

Because of some personal circumstances, we're going to take two witnesses out of order, and I apologize particularly to the folks from CUNY who would otherwise be up next.

The first is Timothy Lunceford.

(The witness was sworn.)

MR. LUNCEFORD: Hello, assembly members. Thank you for allowing me to speak today. I'm sorry, I am about to leave on a long trip for some medical rest, but I

wanted to say that, Thomas Jefferson said, "if the people let government decide what foods they eat and what medicines they take, their bodies will soon be in as a sorry state as there are the souls of those who live under tieranny."

I have personally been vaccinated for seasonal flu myself because of health issues I have. I've also received the seasonal flu vaccination because of health work that I've been involved in the past in hospitals.

These vaccinations were all voluntary. No one said I had to have them. My personal doctor did take the time to advise me to get a seasonal flu shot after a severe illness and put me -- and getting the virus would put me at further illness.

He explained that I had acquired the seasonal flu during an outbreak. It

might present further complication of my illness and other illnesses.

My doctor explained the current vaccine contents and other aspects of the seasonal flu vaccine, including side effects and other problems. None of my doctors have ever tried to force me to get the seasonal

flu vaccine. The other time the seasonal flu came up when I was working in the hospital around children with colds and seasonal flus that they get. It was advised that it was best to get the flu shot so that I did not become ill with my current health issues. All the time I voluntarily accepted the seasonal flu vaccine.

Colds are another issue I wish to discuss today in our conversation as I personally have always stayed away from my work environment and others when I have a cold. But that was my decision. I have been in work situations and banks, law offices as a paralegal, and other environments where workers have come into the building with colds, flus, and other

aspects because there is no way for them to not work and stay home with the flu, cold, or whatever illness.

This should not be the case and workers should be given some sort of payment while out of work for colds and flus, and any management should be able to ask the worker to leave if the illness can cause further illness among other workers, like

cold, seasonal, or H1N1. These workers should be advised that they will receive some type of income being out of work, and I believe that the New York State Legislature should work with corporations around New York State and put together some type of funding like the State Insurance Fund for workers' comp to cover these two, three, four and five days that a worker might be forced to take out for their own illness as well as workers with children.

Now we have a Commissioner of Health, Richard Daines, with a history of conflict over vaccination in the past with his position mandating a regulation that

requires all health workers to be vaccinated for seasonal flu and H1N1, or face unemployment with the loss of their license just because they object to getting the flu vaccination.

I definitely oppose the fact that people with religious objections are not included in the opt-out for this. The regulation includes medical staff and I wonder whether that means the security guards and NYPD officers that have been at my bedside at Bellevue and Beth Israel

Hospitals with my illness, does that mean cleaning staff in hospitals or medical clinics must get the vaccines?

Does that mean the clerk I check in in the clinic or doctor's office must get the vaccine?

Does that mean my pharmacist on Hudson Street or the drugstore on Charles Street must get the vaccine? All have direct contact with patients or employees closely working with patients.

This policy by the health

commissioner was not put into action with any action by the New York State House or Senate. It was never put -- hold on my hearing dog. I'm sorry. She woke up. It was never put into action with any house, any work by the House or Senate. It was never put in a ballot for any New Yorker to vote on, and the health commissioner produced this mandate behind closed doors. What happened to transparency?

We should have known about this two years ago. We should have known about this type of planning through news releases and other things like that. He did not put

the mandate out with any type of education about the flu problems with the vaccination, or if the vaccination would truly work on whatever flu appears on the horizon.

He's not declaring a public emergency in this mandate. I see Governor David Paterson as the only governmental officer able to amend, expire, or dismiss this mandate for vaccination.

And for this year's flu season,

an education in New York to all New Yorkers could have been done in a professional and health conscious way through TV, radio, and newspapers, including professional magazines, bringing up the facts of what the flu is, what the vaccine is, and how the seasonal flu vaccine works, and how H1N1 works.

What are the side-effects and other problems? Health care workers and patients alike could make a decision on their own merit to receive or dismiss vaccinations. We certainly have not been served by the profitable news media's own hypes and sensationalism with their constant blast of flu and H1N1 stories.

The flu vaccine has mercury in

it. This is admitted by our own government and on the federal CDC website. The government admits that the flu. The government admits that the flu vaccines have 50,000 parts per billion of mercury, and the government's own website admits that any amount over 200 parts per billion is toxic

by law.

Looking at my supporting documentation on the H1N1 vaccine, the first multi-dose vials contain thimerosal, and that right there I think is going to go about 91,000 people, and they don't have any way to opt-out because they're healthy if they're a healthcare worker.

I wish to speak to the legal issues regarding this. Looking at the U.S. Constitution and the Bill of Rights, I found -- in violation of this mandate, a violation of the freedom of religion, respecting the establishment of religion, or prohibiting free exercise thereof.

With regard to soldiers, I've heard in rumors and things like that with my healthcare workers, that there's been talk of actually going into private buildings and

things like that to vaccinate someone. I would hope that wouldn't happen because that would be a violation of Amendment Number 3.

Search and seizure. The right of people to be secure in their persons against

unreasonable searches and seizures. That's what I see as a violation by this mandate.

Amendment Number 5, trials and punishment and compensation for taking at issue not being deprived of life, liberty or property without due process of law, and the public and healthcare workers have not been given that.

No person should be held to answer for a capital, otherwise, infamous crime. That's part of that. I didn't mean to read that.

I feel New York State Legislators should rule that this type of vaccination should always be voluntary in light of the U.S. Constitution.

As we've heard, the New York State Nurses Association with 37,000 members has come out against mandatory vaccination. It's unclear whether nurses who are fired because they refuse to be immunized will be subject to unprofessional conduct charges

under the Regents Rules Part 29.

Now I wish to address the profits

for some. How much do the bio-pharmaceutical companies stand to make? This was recently published by Bob Grant on thescientist.com. Our pharmacy companies globally are making millions and billions on the fear of the flu and the preparations for the worst effect by the flu season 2009 and 10. I have enclosed the actual profits reported by Mr. Grant on his web page that I was able to see $1.4 billion in profit in one posting of several pharmaceutical's vaccine's production just on the CDC's orders in the U.S.

There is an individual in New Jersey who is trying to get a federal injunction against compulsory vaccination 30 years after the CDC put out the compulsory vaccination directive. His name is Mr. Vautner. He's actually put it in federal court. It was denied a week ago. He's planned to rewrite and resubmit it pro se, and he's said he will definitely take it to the supreme court.

I'd hope you would follow that

and I put his brief in my summation comments.

I'd like you to answer the question today on how this hearing will contribute to the safety of all New Yorkers at the same time respect their freedom of choice with our testimonies and your comments today. It should not be the State's decision on what enters a human body.

I was asked to read a letter today sent to you, Mr. Gottfried, and Ms. Glick, as well as a copy sent to Mr. Duane that was originally sent to Governor Paterson. Mr. Stevens has said he's willing to end his nursing career as a registered nurse before being forced to receive the flu vaccine or H1N1 flu vaccine. He has never received a flu vaccine in his life and he remains healthy at 73 years old.

He has never -- he has had prior appointments today so he could not be present. He wanted his letter to be entered in today's hearing report.

"Governor Paterson: The high marks of fascism are fostering of fear and secrecy --

CHAIRMAN GOTTFRIED: Excuse me.

MR. LANCEFORD: "The Commissioner of Health, Mr. Richard Daines, recent decision to promulgate Regulation 66-3 making regular and swine flu vaccinations mandatory for New York State healthcare workers smacks of fascism.

I am a New York City home healthcare registered nurse practicing since 1993. I unilaterally oppose any type of mandatory flu vaccine.

Governor, I ask you to consider the following. The regular flu vaccine if poorly matched to the virus in circulation leaves the recipient open for contracting the flu. As to the swine flu vaccine, it is composed of potentially toxic components and has not been subjected to field trials with human subjects at large.

Your commissioner has made no proclamation of a public emergency, what

then is his legal rationalization for regulation 66-3. The whole approval of the regulation was shrouded in mystery.

Will those healthcare workers who refuse the mandatory vaccine be subject to unprofessional conduct charges under the Regents Rule 29?

Governor, you would think that with the statewide shortage of nurses Commissioner Daines would have second thoughts about making vaccines mandatory. Instead, he has stomped about on hob-nailed boots.

I will be comfortable when I'm allowed to weigh all the facts and then reach an informed decision without being coerced.

Governor, you must let this regulation expire and I would hope the legislature would take action to take the mandatory requirement out of the picture."

CHAIRMAN GOTTFRIED: Thank you. Questions?

(No verbal response.)

CHAIRMAN GOTTFRIED: Thank you very much. Our next witness will be the New York Civil Liberties Union.

(The witnesses were sworn.)

MS. LIEBERMAN: Good afternoon. My name is Donna Lieberman, Executive Director of the NYCLU, and with me is our Legislative Director, Robert Perry, and our Senior Staff Attorney Beth Harulez, who has litigated a number of medical privacy cases and is an expert in the field.

The NYCLU has nearly 50,000 members in the state. We're the state affiliate of the ACLU, and we operate out of eight offices around the state.

Our mission is to protect fundamental rights, privacy, and bodily autonomy included.

I want to thank you for having this hearing. I want to comment at the outset that it's kind of shocking that this is the first public hearing on this issue. Not shocking about your behavior, but this is promulgated as an emergency regulation

and a number of people today have alluded to the fact that this regulation has been under consideration for a good two years in secret with input from whoever the Department of Health sought to get input from but not from

the public. That's really unfortunate, it doesn't speak well for the Department of Health, for transparency, for open government and, I might add, for getting the best result.

The New York Civil Liberties Union opposes the mandate for a mandatory set of flu vaccines as a condition of employment for tens of thousands of healthcare workers.

We urge the State Department of Health to withdraw it. The goal of protecting New Yorkers from the effects of H1N1 and seasonal flu is undeniably important, as is the interest of insuring that the healthcare workforce is healthy enough to keep our healthcare system functioning.

The NYCLU's position on this

issue is the product of extensive review of competing interests all of which we have taken very seriously.

But we have to conclude that the mandatory double vaccine program for healthcare workers violates core legal principles and public health policy, both.

In reviewing this policy, we

start with the well-established principal that individuals have a fundamental, constitutional right of autonomy. And that competent adults have a fundamental right to direct the course of their medical care, including the right to refuse treatment.

Any intrusion upon this fundamental right is presumptively impermissible and can only be justified if it's necessary to the advancement of an important societal interest. That's not to say that there are never circumstances where the danger to the public from a communicable disease is so great that state actions that can curtail individual rights are warranted. But those circumstances are rare.

The Supreme Court has said in the famous "Right To Die Case," Cruzan, that in assessing whether mandatory treatment violates an individual's constitutional right, we must balance the liberty interest at stake against the relevant state interests.

We must thus weigh the nature and severity of the disease, the gravity of the harm from it, the means of transmission, the

degree of intrusion on personal autonomy against the likely effectiveness of the vaccine and the availability of less restrictive alternatives to accomplish the same goal.

Many individuals view the vaccines as a minimal intrusion on bodily integrity. To others the intrusion is far more substantial. It undeniably involves injection into the body and can have side-effects, however mild or rare.

These competing views are part of why the CDC recommends and "the risks of serious disease from not vaccinating are far

greater than the risks of serious reaction to a vaccination, but individuals should weight those risks for themselves and determine whether or not to get vaccinated."

As to the nature of the disease, at this point, the CDC director has noted that the H1N1 flu itself does not appear to be more severe than the typical seasonal flu, though, concededly, circumstances may change and responses may be, different responses may be warranted.

As to the efficacy of the vaccine, while few would deny the beneficial

effects of the vaccine, none have claimed that it holds out the promise of eradicating the flu altogether or providing absolute protection against infection.

We recognize that there's -- we have an experience with the small pox vaccine. In 1905, the United States Supreme Court found that a mandatory small pox vaccine was justified. H1N1 is very different.

Small pox is described by the

World Health Organization as one of the most devastating diseases known to humanity. Repeated epidemics of small pox had occurred when the mandatory vaccine was implemented for centuries around the world, killing 30 percent or more of the victims at a rate 300 times greater than H1N1, and leaving most of the survivors, blind and/or disfigured. The vaccine was designed to eradicate the disease and it did.

The H1N1 vaccine, by contrast, is not designed to, nor can it, eradicate the flu. H1N1 vaccine is also different from other vaccines and medications which have been required by the state in various

contexts, like MMR, measles, mumps and rubella, diptheria, and polio, and tuberculosis, tuberculosis medication.

In each of those cases, the vaccine or mandated medication is known to be 100 percent effective in preventing the disease and/or treating it and preventing transmission. Again, H1N1 is different.

Moreover, less coercive measures

to address the threat of flu outbreak are indeed available. A strong program to encourage vaccination combined with employee cooperating in staying home, paid sick leave would help, can go a long way to achieve the public health goal of minimizing individual risks and reducing transmission rates.

And for the very -- for the relatively few healthcare workers who refuse vaccinations, a combination of universal precautions combined with effective respirators or face masks can sharply reduce the risk of infection and transmission, rendering mandatory measures unnecessary and unwarranted.

There's been a lot comment today about the lack of a meaningful education campaign to enlist the health care community

as part of the pro vaccine army rather than ordering the mandate. I think that this is a missed opportunity. We should be plastered in -- our subways should be plastered with -- we should not be plastered, right, Deborah? We have to

acknowledge a joke when we hear it. It wasn't a joke.

Anyway, our subways should be plastered with posters of public health messages. We should not be relying on fear mongering from the TV news. We should have a Health Department that has a concern and has an infrastructure set up to do health education and that conducts these activities in a serious and comprehensive way, in the schools, in the public, in the hospitals, in the doctor's offices, et cetera.

When we balance the interest in this case, the nature of the threat does not now warrant the vaccination requirement for healthcare workers and, indeed, the vaccination requirement exceeds the state's constitutional authority to curtail individual liberties.

New York, we like to be

different, but I'm not sure it's good in this case. New York is the only government entity in the United States that has adopted a mandatory vaccination requirement for

either H1N1 or seasonal flu.

Both the World Health Organization and the CDC have consistently taken the position that inoculation against CDC -- against seasonal flu and now H1N1 is strongly recommended but always voluntary.

Others have listed the other organizations, significant organizations that also follow this recommendation that the vaccine must always be voluntary.

And sound health policy promotes trust and cooperation among the government, healthcare workers and the general public. This makes public education more effective and encourages compliance. Sweeping government mandates that carry harsh penalties are fundamentally at odds with effective health policy and practice.

Indeed, there's evidence of this in the hundreds of complaints, I say hundreds of complaints received by the New York Civil Liberties Union alone. These complaints reveal that the vaccination

mandate is creating conflict between

healthcare administrators who must enforce the mandate and their employees who risk loss of employment for refusing to comply.

It should evoke little surprise that many healthcare workers object to the compulsory vaccination regime. Their training teaches them that no competent adult may receive medical treatment without informed consent.

Now this basic principal is suspended when it comes to their own medical treatment. And not just with regard to H1N1, but for the seasonal flu as well, which poses the same medical issues today as it has for years.

If healthcare workers are confused and upset about compulsory vaccination, what are their patients to think? As reports of healthcare workers refusing vaccinations become public, confusion and worry will grow in the general population. And we all know that this could backfire and discourage other people from getting the vaccines that they should get

and need.

A few years ago the assembly considered and wisely shelved a proposed model State Emergency Health Powers Act, which would grant extraordinary police powers to the government in medical emergencies and relied on police powers quarantine and mandatory treatment.

The discussion with regard to the Emergency Health Powers Act revealed the need for an extensive infrastructure for public health education to enlist the public in efforts to combat health emergency. That infrastructure still needs to be developed.

Finally, our opposition to compulsory vaccination for H1N1 and seasonal flu should not be construed as opposition to the vaccine. Rather, it's consistent with fundamental rights to autonomy and well established public health protocols.

Vaccination should be widely available, which it is not, particularly to vulnerable populations and to healthcare workers. It should be undertaken in

conjunction with a clear, accurate, and accessible public education effort, and it should, as WHO and the CDC recommend, be voluntary.

A New Jersey Appellate Court spoke about these issues I think in a compelling matter, and I'd like to just quote briefly in closing.

"It's possible to reconcile public health concerns, Constitutional rights and civil liberties simultaneously. Good public health practice considers human rights so there's no conflict. Since coercion is a difficult and expensive means to enforce behaviors, voluntary compliance is the public health goal. Compliance is more likely when authorities demonstrate sensitivity to human rights.

And so, for all these reasons, we urge the Legislature to take action and to urge the DOH to rescind the mandatory vaccination protocol. Thank you.

CHAIRMAN GOTTFRIED: Thank you. Well done.

Where in your analysis does the

mandate for measles vaccination for healthcare workers who do not have demonstrable immunity to measles fit in?

The healthcare workers we're talking about, unless they can demonstrate medically, I guess, if they already have immunity to measles, are required to have a measles, rubella vaccination, and also to take a TB test which also is an invasive inoculation, or injection.

How does that fit in on your spectrum?

MS. HARULEZ: Well, a doctor in 1990 challenged those regulations importing the MMR and TB regs and lost. The court said that the measles, mumps, rubella vaccine was a known quantity. That it did in fact do what the small pox regime in Jacobson did. It eradicates the transmission of the disease. It eradicates the person's ability to contract the disease.

In terms of the intrusion in the

first instance, the reg mandates that the healthcare worker be tested for titers in their blood demonstrating exposure or not.

If they don't show the exposure,

then they are mandated to take the MMR shot. That vaccine has a long track record. It has a long history of known, low side-effects, and was deemed by the court in that proceeding to be completely not of the scope of what the H1N1 vaccine would be.

It would be an effective way to control disease in a hospital setting. Measles, mumps and rubella are fatal diseases. If you're in the intensive care unit, if you're pregnant, your fetus can be aborted or suffer severe mental retardation and other disabilities. These are all life threatening and fatal illnesses which can be eliminated and eradicated by a vaccine.

The TB testing has been even of longer duration than the measles, mumps, and rubella vaccine. Yes, there is a needle stick involved there, but, again, well established, no side-effects and the maximum

balancing, the bang for the buck that you get from the testing for TB is much greater when you do the public health balancing against the individual interest.

It was an Article 78 proceeding. It didn't get into the constitutional

issues, but, from our perspective, that's where we see the difference. It's a known quantity vaccine, known quantity blood testing, maximum benefit, eradication of illness. That is not what a seasonal flu shot is.

In a season where you've got well-matched vaccination to the strain that's circulating, you don't generally get more than 70 percent success rate. So you've got 30 percent of your inoculated population still developing the flu. You also have within the 70 percent of folks either a lesser duration, less extreme symptoms of flu, but, again, it's not the silver bullet.

Here, with the H1N1 currently it may be a well-matched vaccine, so this may

be a time where the vaccine may, in fact, reach that 70 percent effectiveness. And in our testimony, we've directed your attention to a report that was issued in June by the Joint Commissions formally known as the Joint Commissions on Accreditation of Healthcare Organizations which is the certifying enforcement arm of HHA.

They co-authored a report that

spoke specifically to the issue of, how do you increase the inoculation, the flu inoculation in your healthcare worker population? They put forward all the studies that show that the benefit from mandatory inoculation is subject to lively debate. There is no proof positive here. We would suggest that you do review that particular report co-authored with the CDC and various other entities, all of whom take the position that, particularly for flu vaccination, it should be a voluntary acceptance of the immunization, coupled with a very strong public education effort and, of course, deployment of a full battery of

infectious disease control protocols.

We're not seeing any of that happening here. We're seeing the flu vaccine being posited as a silver bullet. That's not, in fact, what it does, and it does a disservice to all of the residents of New York State, people who go to the hospital, healthcare workers, to be sold that bill of goods.

CHAIRMAN GOTTFRIED: So if I can distill that down a little, it's a

combination of the mortality rate of the disease and the percentage effectiveness?

MS. HARULEZ: The efficacy of the vaccine.

CHAIRMAN GOTTFRIED: Of the given vaccine.

MS. HARULEZ: Right. Which ties right into the balancing test that the Supreme Court in Cruzan, the Supreme Court back in Jacobson in 1905, and what good public health policy that's evolved over the past 100 years recognizes that you look to the individual interest, you look to the

public police power issue, and you weigh those interests, you consider the severity of the illness, you consider the efficacy of the vaccine, you consider the less restrictive approaches.

The public health approach here is voluntary participation, highly targeted education efforts to hear the Department of Health indicating in the nursing home context that they don't even find out why the nursing home workers decline vaccination is astonishing.

Every other state that has that regime in place ascertains the reason for

the decline, and then works it into their next round of public education and outreach. To hear that that's not happening in New York State in the nursing home setting where routinely the elderly population is most at risk of death from influenza, not this time, because of residual resistance, I guess, but to hear that is just astonishing, and I think demonstrates that the public health infrastructure in New York State needs a lot

of attention.

CHAIRMAN GOTTFRIED: In terms of an individual's right to essentially refuse treatment, if the flu were a treatable ailment, and I guess Tamiflu can help but I don't think it's a cure, what would be your thought about a regulation that said that if a healthcare worker comes down with the flu, they may not come to work unless cured, is that a mandate for treatment?

MS. LIEBERMAN: Of course not, no. That's a mandate that restricts a person's ability to come to work and infect other people. I mean, nobody here is advocating that healthcare workers with the flu should go to work.

What we're advocating is that healthcare workers ought to be given the choice of taking care of themselves to reduce the risk of their getting the flu and to decide whether or not to get a vaccination. That's a very very different proposition.

CHAIRMAN GOTTFRIED: Yes, but the

question would be whether on a spectrum -- I mean, granted a treatment that prevents you from being an infector is different from a treatment that cures you from being an infector, you know, is on a different point on the spectrum, but is it at that point a question of degree, and degree matters?

MS. LIEBERMAN: Well, you know, being forced to get a shot is a very very different than not being allowed into the workplace. Very different.

MS. HARULEZ: I mean, you have a Compulsory Education Law in New York State but you also have the counterveiling directives from all of the school administrators to keep your kids at home if they're sick, simply because you don't want to encourage any sort of degree of transmission.

I think we've heard testimony from some of the nursing professionals and healthcare professionals that, in fact, they're effectively mandated to work even if they're sick. That is a situation that

should not occur, you know, if you're sick, you should stay at home.

And the choice of taking a vaccine or not, knowing that if you get sick you will have to miss work because, as professionals, they're not going to do harm to their patients, they have an ethical obligation not to do harm, they have a professional obligation codified in the regs not to do harm, so you're going to miss work as opposed to, you must take a vaccine.

Whatever the reason is, you know, and, again, it goes back to the lack of public education here. There's a lot confusion around what the vaccines are, whether they've been approved by the FDA, whether they contain or not contain squalene, whether they contain or not contain thimerosal, whether they contain or not contain latex to which many people have allergies, which is not being accepted as a

reason for the opt-out.

There needs to be a lot more attention paid to the way the state is

approaching the management of H1N1 or seasonal flu, this year, next year.

It involves looking at a variety of issues including making sure that the vaccine is available for people who want it, for people who need it, and making sure that for people who choose not to take it, that there are other ways to mediate the effects of the flu, and to keep them from being infectious to other people.

CHAIRMAN GOTTFRIED: Questions?

MR. PERRY: Could I elaborate?

CHAIRMAN GOTTFRIED: Sure.

MR. PERRY: On the issue raised by Donna in her testimony as to the model State Emergency Health Powers Act, because I think it implicates a broader public policy discussion that I hope the legislature will undertake.

Beth Harulez and I appeared before you, Assembly Member Gottfried, in 2002, regarding the model State Emergency Health Powers Act. That bill was shelved, but it sits on the shelf. It's ready to be

enacted the next time some disaster hits the headlines. The concern we've got is that based on testimony that we gave before the city council earlier this year about their assessment of preparedness, and public education, and the ability to engage good communication systems, and engage both the public health community and everyone in a cooperative approach to healthcare problems, we're way way behind the curve of being able to implement that kind of response in a timely effective way.

What we do know is that we have now virtually a century of history regarding public health policy that demonstrates the model is an affirmative, aggressive approach to public education and developing trust and cooperation and collaboration. Whether you look at the Sar's case in Hong Kong, or the 19th Century, the Yellow Flu, what we found is aggressive, mandatory police power approaches to public health that drove people out of the public health system.

What you heard today, which was

quite striking, is the frontline healthcare providers are mistrustful, they're resentful, they're hostile.

I don't expect we're going to see from this community a cooperative, collaborative approach to preventing influenza. You've basically made them hostile to the very effort that the reg is supposed to be accomplishing.

So that's my pitch about the larger public policy approach, and I think this hearing is instructive in that regard.

CHAIRMAN GOTTFRIED: Okay.

ASSEMBLYMAN LANCMAN: I just want to say, I just want to thank you for the way that you frame the issue. We start from the proposition that people have autonomy over their bodies and what gets put into their bodies and, you know, as you say in your testimony, it's not to say that there aren't any circumstances where mandatory vaccination would not be -- wouldn't be inappropriate, but the whole conversation, and I don't know if you were here earlier

for the Department of Health's testimony, but the whole conversation framed by the Department of Health seems to be, well, we're going to impose mandatory vaccinations. We think it makes sense. And nobody has proven us or shown us, you know, to the contrary why it would be dangerous or inappropriate.

That approach, in my view, and I think that's what your testimony supports, is backwards. You know, they need to come forward with very very strong evidence for why mandatory vaccination is necessary and essential to the public health. I really haven't heard that.

I'm very concerned by the fact that, as you know, we brought out earlier, New York State is the only jurisdiction in the country that is imposing this, and, look, if we're trail blazers and we're leading the way then, as I said earlier, I'm so proud to be a New Yorker.

But until we hear that kind of proof, until the department has met its

burden, to use the lingo, then I'm -- the mandatory vaccination troubles me very much.

Anyway, I appreciate the way that you've been able to frame the issue in a way that we weren't able to earlier.

Thank you very much.

MR. PERRY: The report that Beth Harulez referred to was footnote seven, and it does indicate as you suggest that the evidence is highly mixed as to the effectiveness or success of this mandatory approach, the police powers approach, as I referred to it.

CHAIRMAN GOTTFRIED: Technical question. Have you e-mailed us your testimony?

MS. LIEBERMAN: Probably not. But we will when we get back to the office.

CHAIRMAN GOTTFRIED: Please do. And, by the way, I don't mean to just ask you that question. Anybody else who hasn't e-mailed us your testimony as an attachment either in Word or PDF, please do. It makes it a lot easier for us to make it available

to other.

MS. LIEBERMAN: We're also e-mailing it to -- we're sending the letter, which is comparable, to the commissioner.

CHAIRMAN GOTTFRIED: Good. Thank

you.

MS. LIEBERMAN: Thank you.

CHAIRMAN GOTTFRIED: Okay. Our next witness is Howard Apsan, City University of New York.

(The witness was sworn.)

MR. APSAN: Chairs and members of the committee, thank you for inviting the City University of New York to testify before you today. I'm Howard Apsan, CUNY's Director of Environmental, Health, Safety and Risk Management, and I'm pleased to represent the university at this hearing.

CUNY is the largest urban public higher education institution in the United States. We have 23 senior colleges, community colleges, graduate schools, and professional schools, and we have more than a half a million students, faculty and

staff.

The Office of Environmental, Health, Safety, and Risk Management is coordinating CUNY's effort to minimize the potential impact of an H1N1 outbreak.

In the following few minutes, I would like to share the three key elements

of our approach, coordination, preparation, and communication. And I will be happy to answer any questions.

Coordination. CUNY acknowledges the leadership role of the New York City Department of Health and Mental Hygiene in assessing health risks and setting citywide health policy.

There are many sources of information and guidance on H1N1, but CUNY follows the health department's lead in pursuing a consistent and coordinated program to minimize the spread of influenza.

We coordinate with the Health Department, which, in turn, works closely with the Centers For Disease Control and other research institutions to obtain,

evaluate and share evolving epidemiological data. We're also part of the citywide coordination effort that includes the mayor's office, the Office of Emergency Management, the Health and Hospitals Corporation, the Department of Citywide Administrative Services, and other agencies that participate actively in regular conference calls, meetings, and training sessions.

During last spring's H1N1 outbreak, CUNY participated in daily conference calls with the Health Department and the Office of Emergency Management to obtain up to date surveillance and monitoring data, and to discuss infection control strategy. We then conducted daily internal conference calls to share the information within the CUNY community.

Preparation. To quote Tom Ridge, America's First Secretary of Homeland Security, hope is not a risk management strategy. At CUNY, we certainly hope that the initial assessments are accurate, and

that this fall's H1N1 will be as mild as last spring's.

Nevertheless, we will try to be prepared for any contingency. To that end, we've drafted and updated a pandemic influenza response plan that offers university-wide, campus specific, and departmental guidance.

The plan was distributed throughout the university and administrators, centrally, and on the campuses, have been asked to implement the

plan in their areas of responsibility.

We have also taken steps to foster a culture of infection control throughout the university. We've posted "cover your cough" and hand washing posters throughout our buildings. We've asked our campuses to make sure that there's ample soap in the restrooms. Hand sanitizers have been placed in many high traffic areas and distributed widely. And we're encouraging everyone in the CUNY community to stay home if they are sick, and to say there until

they have been symptom free for 24 hours.

Communication. An effective flu-prevention program depends on effective communication. To implement the CUNY H1N1 program, we will continue to communicate a uniform message throughout the university. We have briefed our campus presidents, our senior executives, our union leaders, and many of our managers to ensure that they understand the scope and importance of CUNY's H1N1 preparedness efforts.

For the wider CUNY community, we are sharing flu information through e-mail and web-based updates. In fact, for the foreseeable future, we have decided to

maintain a permanent H1N1 hot button on the CUNY homepage that's www.CUNY.edu, that provides the latest H1N1 updates. We ask our campuses to link to the CUNY updates in any customized H1N1 communiques. This will minimize potential for confusion and ensure that we are providing a consistent message throughout the university.

In closing, like everyone in this

room, we hope that any recurrence of H1N1 in New York City will be mild and limited but, as I mentioned, we are responsible for a CUNY population of half a million, and we can't afford to let hope be our risk management strategy. Thank you.

CHAIRMAN GOTTFRIED: Thank you. Questions?

ASSEMBLYWOMAN GLICK: Just a few questions. CUNY is viewed largely as a commuting school, but there have been some resident facilities. Are you doing anything in particular in those circumstances?

MR. APSAN: Yes, of course. We have four schools now that have resident facilities; Hunter College, City College, Lehman College, and Queens College. And

we've been meeting with our door managers independently and we've involved them in our risk management programs and meetings to make sure that they have been addressing the residential concerns as well as they possibly can.

Of course, when students are

living together, it adds additional difficulties in managing the spread of influenza, but hopefully we will be able to use the expertise that's been available at other universities that do have large residential communities to help us.

ASSEMBLYWOMAN GLICK: Like many of the SUNY campuses, CUNY is experiencing a tremendous volume of students coming to its campuses, and much more overcrowding than there was maybe 10 years ago.

And with dollars and in scarce supply of various systems being somewhat strained, air-conditioning maybe not working, and some of those other issues. So what -- if you have a concentration of people who daily ride on the subways, and then come to your campuses, are there any strategies that you think you can employ that might be useful, or things that you're

thinking about doing, to minimize the potential for contagion in sort of closed systems?

MR. APSAN: Yes. Thank you for

asking. Of course, our campuses are, in many cases, their resources are being stretched and tested. When we talk about the spread of infectious disease, we talk about the problems associated with that, with crowded situations.

At this point, we are going to follow the steps that I mentioned so far in my testimony in trying to make sure that our students aware of the concerns, that they're taking the proper precautions that they can, that we provide them with the kinds of disease-spread prevention tools that they need, and hopefully that will suffice at this stage.

If things change, if circumstances change, we do address those kinds of contingencies in our influenza response plan, but I'm hoping that that's a way off.

ASSEMBLYWOMAN GLICK: Well, I ask this because I was watching something, and

it was a fellow who runs a company that does computer repair. They come into offices,

and they're their number one thing for all of their technician is that they provide them with wipes or whatever so that before they touch any keyboard, before they sit down at anybody's desk, before they use any anybody's phone, that they take care to wipe surfaces down.

Is there any provision at the computer labs throughout CUNY to ensure that there is some type of surface sanitizer that is not going to destroy the equipment so that we don't have students trying to figure out the best way to keep themselves safe and perhaps damage equipment? Is there anything that's being done?

MR. APSAN: What you're suggesting is a very good suggestion but it's a complicated one because of the points that you make. What we're doing -- we're doing two things really. We're trying to re-double our efforts to make sure that we are cleaning everything on a regular basis and as often as we possibly can given existing resources.

The second thing that we're doing is we're trying to make sure that -- the spread isn't going to come from the keyboard as much as from the hands. So we're trying to make sure that people have -- certainly soap in the bathrooms when they need it, and hand sanitizers readily available in most instances so that they can make sure that any kind of germs or viruses that are on their hands are being cleaned.

ASSEMBLYWOMAN GLICK: Thank you.

CHAIRMAN GOTTFRIED: Thank you. Next is Dr. Daniel Baxter from the Ryan Community Health Network.

(The witness was sworn.)

DR. BAXTER: Good afternoon and thank you, Honorable Members of the Assembly for the invitation, and on behalf of the William F. Ryan Community Health Network, of which I am the chief medical officer, we appreciate this opportunity to come before the Assembly to discuss H1N1 issues that are particularly pertinent to New York's community health centers.

As I'm sure you're aware, New York's community health centers are medical homes for a wide diverse patient population, especially those who are insured, and the community health centers in the state and in the city in particular have a very proud history of working closely with health officials in any public health emergencies.

For example, the ongoing HIV pandemic, the events surrounding the 9/11 terror attacks, and the H1N1 outbreak this past spring and early summer. In all of these emergencies, community health centers have worked closely with city, state and federal agencies, and have committed enormous amounts of time, effort, and expense in addressing these issues.

As an example, the Ryan Community Health Network, has in place a very comprehensive infection control policy including how to address serious airborne pathogen outbreaks, not only influenza, but small pox, plague, or other serious infections.

As part of its support of and

cooperation with city and state agencies, the Ryan Network, while acknowledging the understandable concerns and sensitivities of healthcare workers, strongly and absolutely supports Commissioner Daines' mandate for mandatory vaccinations for all healthcare workers.

And, as we speak, the Ryan Center is immunizing its staff against both seasonal and H1N1 influenza.

The reason that we've not had a lot of problem at the Ryan Center is that we've had both administrative and clinical leadership, and we've had ongoing staff education about this issue. As an example, on several instances at the request of our local union representatives, I met with them during their lunch breaks to discuss any issues or concerns that they might have about this mandate. We found that with appropriate education and treating staff members with respect, they eventually understand the importance, not only for our

patients, but to protect themselves and their family.

Yes, of course, as New Yorkers,

we don't like to be told what to do, but I am confident that members of the Assembly can make the distinction between the validity and wisdom of a public health mandate versus the process by which the mandate was arrived at in the first place.

I would, however, inject some suggestions and cautionary messages that the assembly should consider. Yes, the city and state can count on the support of community health centers in facing public emergencies such as H1N1, but it's very important that our cooperation does not threaten the viability and ongoing mission of health centers in meeting the other myriad medical needs of our patients.

Put frankly, the legacy of H1N1 influenza must not be the cannibalization and degradation of health centers which will be committing and are committing considerable financial resources including

major commitment of staff to help vaccinate the community at large.

As I'm sure you know, the Department of Health is quite keen to use as many health centers as possible as points where the community, people that are not

registered patients, can come in and get the vaccination.

Now, as you probably know, influenza vaccination is not just a case of lining up people in assembly-line fashion giving them the flu jab, rather, it requires a registered nurse, at least, to screen the patient for any possible contraindications to have the patient sign a consent form, and, by the way, we're still hoping that the state will waive the requirement that a patient needs to consent to allow to have their vaccination reported to the citywide immunization registry.

So you have to give the patient a vaccine information sheet. You have to make sure they understand it. You have to make sure that they've signed the consent. Then

you do a very quick targeted screening to make sure it's safe to give the vaccination, and then you give the vaccination and then you document it.

Now this has to be done by at least a registered nurse. And I know that this will touch on all sorts of political sensitivities, but if community health

centers are going to be able to help with mass community-wide vaccinations, we're going to have to have a waiver that will allow a licensed practical nurse to do all of these steps.

An LPN can physically give the vaccination, but only at the order of an RN or another higher healthcare worker. And RNs are very limited at community health centers.

Moreover, as you well know, the state's health centers are financially strapped. In fact, it's no secret that the Ryan Center has had to cut back on services and even lay off staff.

So it's very important that this

intensive commitment of staff to help community-wide vaccination does not effect the viability of the health center, and let me give you just an example of sort of the catch 22 situation that we're in. Yes. We know that the Department of Health has said that although the vaccine is provided free and the equipment for the vaccine administration is provided free of charge, they said that we can charge an administration fee.

But that's easier said than done. It's not just a question of saying to people that come in from the community, okay, pay us $5 or $10. No. We would have to bill their insurance and, in order to bill their insurance, Medicaid, Medicare or private carriers, we would then have to undertake the very time consuming, and labor intensive task of registering them as new patients, which, of course, would increase waiting time, and completely obstruct the intention of mass community-wide immunizations.

As a result, yes, it's easy for

the DOH to say, yes, you can charge for a vaccine administration fee, but it would actually cost us more in terms of staff registering patients in order to bill for that fee.

So perhaps there are a couple of recommendations or requests. Number one, if we really do get to a situation and, as you've heard, hopefully we won't, but if you get to a situation where there's going to be a major surge of the community coming in wanting vaccinations for influenza, for small pox, whatever, we need -- the

community health centers need a waiver to allow licensed practical nurses to screen patients and then give the vaccination on standing orders.

Number two, it is odd to say the least that we need to get written consent from a patient that is a vaccine recipient to report that vaccination to the citywide immunization registry. The Department of Health has said, well, if they refuse consent, you can still go ahead and give

them the vaccine.

And, number three, quite frankly, like everyone else during this great recession, we need money, and it is basically disingenuous and glib to say, well, you can charge for an administration fee because, as I said, it would cost us more to register the patient in order to bill the insurance than we would get back and, moreover, it would defeat the goal of having very quick, expeditious vaccination of the community at large.

So, in conclusion, the community health centers of New York State are proven reliable partners in cooperating with the city and state in public health emergencies,

and we are willing and able to do the same with H1N1. But it's very important that this cooperation not come at a considerable cost to the already overstretched safety net providers because, if it did, it could lead to ultimate deterioration of the general public health.

Thank you for your attention and

I'll be happy to answer any questions.

ASSEMBLYWOMAN GLICK: Let me ask you a little bit. It was a little bit of a surprise to hear you asking for a waiver for a licensed practical nurses. This would be, I guess, a waiver for their -- based on the scope of practice, that does not allow them to do so, are you asking for an emergency waiver, are you asking for a blanket waiver going forward? What exactly --

DR. BAXTER: I would say an emergency waiver.

ASSEMBLYWOMAN GLICK: That would be in effect for --

DR. BAXTER: For the flu season or as need.

ASSEMBLYWOMAN GLICK: Next flu season, this flu season?

DR. BAXTER: It depends upon the severity of the flu season. I mean, we only have at the Ryan Center three registered nurses who are already doing a total of six different jobs. And for just the immunization initiative that we have for our

patients and also for our staff, it takes a considerable amount of their time.

The only -- as I said, an LPN can hand out the vaccine information sheet, can have the patient sign a consent, then we have about four or five yes or no questions that we tick down and ask the potential vaccine recipient.

And if the answer to all the questions is no, then they have the standing order to give the vaccination, they observe the patient for any untoward side-effects. They educate the patient about any possible side effects.

It's, as I said, I might as well want to win the mega million lottery tonight to want that waiver to come to pass for reasons that are better left unsaid, but it really does not, just speak as a clinician, and working with RNs and LPNs, it really does not make any sense when you're dealing

with something as fairly straightforward as vaccination.

ASSEMBLYWOMAN GLICK: Let me ask

you this, there was a rather lengthy process by which the legislature advanced the authority to pharmacists for the administration of vaccinations for both influenza and pneumonia vaccine.

Do you think that it -- that that process of discussion and investigation was a waste of time?

A. No. Not at all. I mean, with all due respect, we're not talking about rocket science or brain surgery here. And I would even argue, and this is in no way to denigrate the training and education of pharmacists. My brother-in-law is a pharmacist, and --

ASSEMBLYWOMAN GLICK: I'll tell him what you have to say.

DR. BAXTER: But I would argue strongly that an experienced licensed practical nurse has had more patient experience in dealing with patients about specific clinical issues than a pharmacist does.

25 I think that any healthcare

professional, in the broad sense of the term, should be able, with a very carefully structured -- I mean, as you well know, it's not just a question of lining people up and giving them a shot but, on the other hand, once you have a system and, you know, the Ryan Network is no more unique than other places in that regard, once you have a system and, above all, have back up. If, you know, the staff, the RNs know that if there are any questions or concerns, they can call me or someone else in the medical leadership to answer the question.

So it makes more sense frankly to allow LPNs to administer the screen and administer for flu shots than it even does for pharmacists. Although I fully support the efforts to bring the pharmacists in on this as well.

ASSEMBLYWOMAN GLICK: The waiver to give consent to send -- you're looking for a waiver on the informed consent for the sending of people's names to the city vaccination registration --

DR. BAXTER: Citywide immunization registry, yes. This has just come up recently, and again, please understand, I'm not complaining at all, but a lot my time of late has been with e-mails back and forth trying to understand and -- all the various details of the H1N1 program, the vaccination, and so forth, and my understanding, and I wouldn't bet my life on it, but my understanding is that the patient must give consent to allow his name to be sent to the citywide immunization registry, which is what the DOH wants.

And so the question was asked, we have these weekly or twice a week telephone conferences with officials from the Department of Health. They say that, well, yes, ideally they should sign the consent but, if they won't allow it, you can still go ahead and give the vaccination. And that -- and, again, if I am correct in this, I mean, having them sign a consent for information like that, I think will just cause all sorts of problems in terms of the

city not getting the data that it needs and that it wants. I've been told that there may be a waiver any day now, but --

CHAIRMAN GOTTFRIED: Considering that the City Health Department made it mandatory for you to report people's blood sugar test results whether they like it or not.

DR. BAXTER: We live in a very complicated world, assemblyman.

CHAIRMAN GOTTFRIED: A couple of questions. On the question of the administration fee for a walk-in essentially, roughly what would that fee be?

DR. BAXTER: I have no idea. I'm sorry. I'm of the old school where you know medicine should be a profession and not a business. I would say --

CHAIRMAN GOTTFRIED: Do you know if it's --

DR. BAXTER: $10. $15, no. Our sliding scale fee for an uninsured patient, the lowest, 200 percent below poverty level is $32 which is an all-inclusive fee. But

if it was just for service of immunization, I can tell you it definitely would not be

more than $32, but I'm probably cutting my own throat for my president and CEO to say that 10, 15, $20.

But it would basically be what the insurance would pay, and I should know this, but I don't know what Medicare and Medicaid pay for a vaccination visit.

CHAIRMAN GOTTFRIED: I mean, I can certainly understand where the paperwork might well make it, you know, might be a lot more expensive to administer than the fee that you would get if that were -- I mean, if that were the beginning and the end of the relationship with the patient.

And the reason I ask what the amount is that, you know, it may just make sense to say it's X dollars, you know, pay it or go to your doctor.

But on the other hand, you know, certainly if there were a way to reimburse you in some way other than that, that would be a good idea. Of course, if we had a

single payer system, we wouldn't be having this discussion.

DR. BAXTER: Amen.

CHAIRMAN GOTTFRIED: I think

that's it. Just a small point on the waiver question. My guess is that -- well, I don't know that anyone in state government in the executive branch or in either the health or state ed has authority to waive the scope of practice requirements. I think that might well require a statutory amendment.

DR. BAXTER: Unless there's some emergency but, as has been pointed out --

CHAIRMAN GOTTFRIED: It's not the end of the world and, it's only lately, two or three years ago that we passed legislation empowering RNs to do immunizations. They were doing them for many years before that, probably for a century or so before that, and then someone noticed that the law didn't quite say that they could, so we clarified that.

DR. BAXTER: I'll just say this, there have been lots of problems and

glitches, but, nonetheless, the city and State Departments of Health in terms of dealing with this influenza program have just been absolutely brilliant.

There are times that, you know, you just throw your hands up, but at the end of the day, if this were anywhere other than

New York City or New York State, we wouldn't know what we would do. So I just want to give me best compliments to the city and State DOH and thank you for inviting me.

CHAIRMAN GOTTFRIED: Next is New York Association of County Health Officials, Joan Facelle, who will probably want to note that the New York City Health Department is not the only good health department in the state.

(The witness was sworn.)

DR. FACELLE: Good afternoon. My name is Dr. Joan Facelle and I'm the health commissioner in Rockland County, and I'm here on behalf of the New York State Association of County Health Officials.

Today with me is Linda Wagner who

is the executive director of the organization and she'll be here to assist if there are any questions.

First of all, I would like to say thank you to Assemblyman Gottfried, Lancman, and Assemblywoman Glick and all the honorable committee members for the opportunity to discuss the ongoing work and needs of public health departments, as those

of us in public health respond to this global pandemic.

I know you had the opportunity this morning to hear from my colleagues in New York City, and today I'm here to represent both myself and the 56 other local health departments in New York State.

First I want to start by acknowledging the strong work being done by our partners at the New York State Department of Health, and at the federal level, the Centers for Disease Control and Prevention.

Commissioner Daines and his outstanding staff at the New York State

Department of Health are providing strong leadership and support for local health departments daily, and we value the robust partnership that we have with them.

We are also very fortunate to have Dr. Tom Frieden, our former colleague from New York City, now leading the federal response. He's intimately aware of the work of local health officials from his recent tenure as New York City's Health Commissioner, and he's made sure that there's ongoing direct communication between

the CDC and local health departments as we move into the next phase of the H1N1 pandemic.

It's reassuring to us to have strong transparent partnerships with both the State Department of Health and the CDC who have been sensitive and responsive to local Health Department needs and concerns as we undertake this massive response effort.

As equal partners with the New York State Department of Health in promoting

and protecting the public's health, local health departments apply a population-based approach to building robust communities that provide their residents with a healthful quality of life.

Local health departments emphasize health promotion and disease prevention through a combination of regulatory enforcement, education, oversight, quality assurance, and direct services.

Evidence based health promotion and disease prevention are investments in the future and provide the foundation for a

strong healthcare system. An important part of maintaining this foundation is the assurance of sustained and inadequate funding commitment for local public health activities by the state.

The work being done by public to address the H1N1 pandemic is an example of the critical importance of continued support of a strong public health system in New York State. The public health system works daily

to assure community health and safety and to recognize and respond to emerging public health threats.

To that end, before I share some highlights of our response efforts related to your areas of interest, I must express our grave concern regarding resources for local public health activities. As we face what, for many of us, may be one of the biggest public health challenges of our careers, I and my colleagues throughout the state are struggling to maintain local public health infrastructure in the wake of local, state, and federal budget cuts.

Ironically, we are facing this pandemic in the same year that direct state support for public health preparedness was

eliminated. While short term federal funds have been made available to deal with the present crisis, at the local level, we are struggling to maintain basic services. Our local public health infrastructure is the who and how behind our ability to respond to this or any other emergency or large scale

event.

Please understand that this goes beyond having the necessary clinical staff and supplies, those are critical. We need our secretaries, clerks, epidemiologists, health educators, and environmental health staff to provide the educational, logistical, fiscal and data support that are necessary to respond.

Also, it's important to note that the federal and state governments require the same level of response, preparedness, and reporting of all of us, regardless of size and resources.

Yet, we cannot respond in the absence of robust planing and without well-trained, prepared staff. Public health workers too are first responders in our community. Just as you would not want fire

or police services to respond to a call without trained staff and working equipment, so must we maintain a trained staff, upgrade equipment as necessary, and prepare for public health crises. Right now our

departments are struggling to maintain our capacity to provide everyday services. We will be further pressed this year to respond to this pandemic.

Even as we are asking our staffs to work harder with less resources to protect our citizens, many are wondering if they will be employed come the new year or if they will be facing furloughs or erosions in pay and benefits.

In other words, one-time funding cannot replace long term sustainable funding. Without the sustainable funding, we will soon be forced to make hard choices about which services will have to be delayed or eliminated. Unfortunately, disease and other natural and man-made health hazards will continue to put our citizens at risk regardless of the economic situation. It is critical that we have your support throughout this challenging time.

Still, in spite of these

challenges I've elaborated, local health professionals are responding. One of our

key roles is disease surveillance. Surveillance is a critical tool at the local state and federal levels for monitoring the extent of the spread of H1N1 in our communities, the severity of the illness, potential changes in the behavior of the virus, and for identifying specific groups within the population who may be at increased risk such as pregnant women.

Local health departments are and will be investigating reports of unusual disease clusters, monitoring any increased hospitalization to assess potential strains on the local health care delivery system and resources, and investigating fatalities due to H1N1.

We will also be working with schools, colleges, childcare facilities and other congregate care settings to monitor absenteeism to identify increases in illness.

All these tasks are important to inform our understanding of the disease, and to be able to implement community mitigation

strategies.

At this moment, as we prepare for the start of the flu season, and as the H1N1 vaccine starts to roll out, our efforts are focused on administering and distributing vaccines. Nationally, and in New York State, we have a complex health care delivery system and we will need all our local partners in the healthcare community to work with us to get vaccine to those who need it. This includes our hospitals, federally qualified health clinics, private providers and practices and schools.

Distribution needs to be managed to ensure not only safe production of the vaccine, but also safe delivery and appropriate tracking. Local public health professionals are working with the state and federal government to ensure that vaccine is pushed out into our communities and administered as quickly as it becomes available so that it reaches our most vulnerable priority populations.

This needs to occur both through

distributing the vaccine to our local healthcare provider community so that they can reach their patients, and where needed to provide it through our own clinics and mass vaccination sites to ensure that vaccine is also available to those without medical homes and where there is limited provider capacity.

Vaccine is key to disease prevention and we're fortunate that it's becoming available. Even so, we know that we will not reach everyone who could be vaccinated and that we are all still at risk for contracting H1N1. We must, therefore, also continue to promote basic preventive measures through partnerships with providers, educators, those who serve vulnerable populations and the media.

Most importantly, some of the best preventative and care measures are those that we must each take as individuals. These include frequent hand washing or the use of hand sanitizers when that is not possible, covering our mouths and noses when

coughing or sneezing, staying home when ill, and not returning to work or school until we can assure that we are healthy and will not spread disease.

We must all take the time to become educated about the vaccine, encourage those at highest risk to be vaccinated as soon as possible and educate individuals on when to seek medical care if they become ill so that we can avoid unnecessary death and severe illness while managing our precious healthcare resources.

In closing, I want to share with you something that I had the chance to hear at the beginning of this month at a meeting with my colleagues from around New York State. We were gathered for an annual summit in Rome, New York where we discussed the importance of robust public health laws, of assessing the priority health needs of our communities, improving our business practices, and, of course, H1N1.

We were joined by the county executive of Oneida County, Tony Pichenti,

who welcomed us to his community and shared some thoughts with us on his perspective of public health.

Mr. Pichenti said that he viewed public health as a primary responsibility as a local elected official. Protecting the health and safety of his citizens was, in his view, an essential core function of local government.

As public health professionals, we do this every day, but when we are in a global disease pandemic, we need the support of our elected officials more than ever.

I appreciate you taking the time to hear from us and look forward to working together with you to fight this crisis. I also look forward to your ongoing support of the public health system in New York State that works every day to protect our citizens and keep our communities safe and healthy.

Thank you very much.

CHAIRMAN GOTTFRIED: Thank you. And, in particular, I want to thank you for taking to the time to remind us about the

importance of our public health infrastructure, and, in particular, the need to support it financially. That is often an easily forgotten part of our state budget, and an easy target for governors to propose

cutting, and not always easy to explain to people why it needs to be supported.

When you don't have vehicles with sirens on them or personnel with guns on their hips, people sometimes forget the importance of what you're doing to advance a safe and healthy community. Thank you.

DR. FACELLE: Thank you.

CHAIRMAN GOTTFRIED: Next is the Professional Staff Congress at CUNY.

MS. BROWN: Yes. The others didn't make it.

(The witness was sworn.)

CHAIRMAN GOTTFRIED: Just pause for a moment. Sorry, voicemail from my wife, never know when it's going to be urgent. Go ahead.

MS. BOWEN: Good afternoon, distinguished and long suffering members of

the assembly.

I want to thank you for your foresight in holding this hearing and particularly for the recognition suggested by the presence of the Education and Higher Education Committees that educational institutions require special protocols of flu prevention.

I'm the president of the Professional Staff Congress, CUNY, the union that represents the 22,000 faculty and staff at the City University of New York.

The core mission of the our union, as expressed in our Constitution is to advance the professional and economic interests of the faculty and the staff, but also to advance the interest of the students and the City University.

In a discussion of influenza, the interest of the faculty and staff are inseparable from the interest of the students.

My message is simple, but alarming, and you'll see that it does

contradict some of the message that you've heard earlier about CUNY. My message is that CUNY has not developed or implemented an adequate H1N1 influenza prevention plan.

You've already heard from a representative of CUNY who has told you about the efforts that CUNY is making. But this is not really about efforts. The issue here is results. We don't deny that CUNY has made some efforts, and they've

consistently been willing to discuss those efforts with us, but CUNY's planning reveals a failure to grasp the essential fact a university, especially a public university, as large and as overcrowded at CUNY is at special risk in the event of an influenza epidemic that targets the young.

CUNY cannot be treated like just another workplace, important as workplace prevention measures are. Like the public school system, CUNY recognizes a special approach to influenza prevention that recognizes the unique properties of an educational institution and the fact that

this flu has targeted the young.

The briefing provided by the City of New York to the municipal unions on September 1, indicated that New York City in the public school system has made plans to provide vaccine to students, has blanketed the schools with information, and has made a commitment to providing soap, hot water, and drying facilities in the bathrooms.

CUNY has done nothing comparable. To date, CUNY has developed only a standard workplace plan, and has failed to implement even that plan adequately.

I understand that this is a serious allegation and the union does not take it lightly, but I feel compelled to speak out to protect the safety and health of our 22,000 members and more than 480,000 students.

As the PSC has indicated to the CUNY administration, the interests of the union and the university on this issue should converge. One college student in New York State has already died from swine flu

this year. No one wants there to be another. The PSC calls on CUNY to put in place the simple prevention measures that can make a life and death difference. That student was at Cornell, by the way.

CUNY's H1N1 prevention plan is not adequate. I want to start with the plan and then talk a little bit about the implementation. The PSC starts from the position that CUNY shares our view, that CUNY administration shares the view that CUNY must be protected.

We're not here to question CUNY's intention, but CUNY's plan needs more imagination, more analysis, more focus and

more energy.

The Centers for Disease Control have recognized that universities are at an elevated risk of H1N1 contagion and have issued special higher education guidelines, but including the Higher Education Committee at today's hearing, the New York State Assembly is acknowledging the same fact.

If it is true, as the CDC says,

that all universities are at an elevated risk of H1N1 flu, then it is especially true of CUNY given the age group of our students, CUNY's location in an urban setting, it's size and it's intense overcrowding. This is not the time to rely on hope.

CUNY must develop and implement and ensure compliance with a much more systematic and aggressive prevention plan. The union would site four factors that contribute to the need for an especially high need for a special comprehensive plan for CUNY.

First, CUNY represents a concentration of people in the high-risk group of individuals aged 24 or younger. According to CUNY's own data for fall 2008, 71 percent of matriculated undergraduates or

96,623 undergraduates are aged 24 or younger.

Individuals in this age group showed an elevated risk of disease in the first wave of the epidemic. In addition, thousands of CUNY students are in another

high-risk category, as they are young parents caring for children six months of age or younger.

Second, CUNY, like all universities, is not just a place where thousands of people work, it is also a place where more than 480,000 students congregate. The concentration of students on a single CUNY campus is even greater than the concentration in the public schools.

At Borough of Manhattan Community College right down the street, for instance, more than 18,000 students are enrolled. CUNY's plan for swine flu prevention should take into account the special risks proposed by such an environment, such as cleaning -- and we can talk about that later. One example, the faculty at BMCC were told to wipe down the desks in their classrooms. That is not a flu prevention plan.

Third, CUNY is overcrowded. Not only is the university normally a place with a high concentration of young people, it is at a record high enrollment right now. And

Assembly Member Glick already spoke about this. Lab technicians report that there is no one to clean a computer mouse that might be handled by 40 or 50 students a day.

The CDC recommends that should conditions of increased severity develop, "there should be at least six feet between people at most times." Exactly. Right. At CUNY campuses, we would be lucky, in many instances, to have six inches.

Fourth, CUNY's current policies on absences and sick leave are a disincentive to comply with the single most important factor sighted by the CDC "promote self isolation at home by nonresident students, faculty and staff."

Despite repeated requests by the union, CUNY has yet to adjust any of its existing sick leave policies to facilitate self isolation. We are especially concerned about the dangers of discouraging self isolation among CUNY's 9,000 part-time instructional staff.

Adjuncts at CUNY receive

essentially one sick day per semester, and, critically, are not allowed to accumulate sick days from one semester to the next. That means that you can have an adjunct who has taught at CUNY for 15 years, who is infected with H1N1 flu, and then has to choose between doing the right thing, staying home, and losing income.

We feel that is an untenable situation in which to place an employee and further that it puts the whole CUNY population at risk unnecessarily.

The PSC calls for a comprehensive and rigorous prevention plan. In the meantime, however, we are concerned that even CUNY's existing plan is not being aggressively implemented.

I did notice that the CUNY representative didn't give specifics, so let me give a few. A university would appear to be the perfect place for an education campaign. Yet, CUNY's education campaign has been flaccid.

As of early October, eight of

CUNY's 17 undergraduate campuses still presented no information about H1N1 on their website's home page. Many colleges have sent out just a single e-mail communication to the entire faculty, staff and students. A much more systematic, creative approach is necessary, and then followed up by inspection.

On the basic issue of cleanliness, CUNY also falls short. There are entire CUNY buildings without hot water. The Nam Building at New York City College of Technology has not had hot water since July, and at Bronx Community College, neither Colson nor Meister Halls has hot water now. NAM still doesn't, by the way.

Obviously, proper hand washing in these buildings is impossible. An informal survey of 10 bathrooms at the Brooklyn College revealed two with no hot water and zero with best practices hygiene signs posted.

In addition, surveys at Brooklyn College of Ingersoll Hall, Boylan Hall, the

West Quad, and the Library revealed no hand sanitizers available. A survey of seven bathrooms at the Bronx Community College found four with no hot water, and one closed because it was out of order. None had signs on hygiene posted, and several lacked either paper towels or functioning hand dryers.

A survey of seven bathrooms at Queens College found six without hot water and none with signs posted. Obviously, this is not a scientific survey, but these spot checks reveal a lack of compliance with best practices at a time of heightened flu danger.

Nothing is more basic and simpler to do than allowing students, faculty, and staff to practice good hygiene. It is the university's responsibility to make such hygiene possible.

The H1N1 flu prevention plan CUNY needs. The PSC calls on the university, in conjunction with city and state health authorities, to address H1N1 planning, implementation and monitoring with an

approach that is adequate to the situation.

While CUNY's planning appears to include some of the necessary elements, the university should ensure that each college plans for, implements and monitors compliance with the following at a minimum:

Adequate and repeated information on flu prevention, and health care resources on every campus through both electronic and print media;

Provision for vaccination for students, faculty and staff who elect to be vaccinated, and such provision could be modeled on the plan for the middle school and high school students in the public school system;

Provision of soap, hot water, and drying facilities in every bathroom on every campus and every work site every day;

Posting of signs in every bathroom about hand washing and flu prevention;

Provision of hand sanitizer dispensers throughout every campus,

especially in areas of high use such as libraries and labs;

Placement of increased personnel who are necessary, and the resources

required to provide frequent cleanings throughout the day of high-touch surfaces, such as desks, computer key boards, and doorknobs;

Formation of a stakeholder's task force on every campus, as recommended by the CDC to meet weekly for updates on flu incidence and prevention. The task force should include representatives of the students, faculty staff, and their unions, as well as the administration and health personnel. It's very simple to do and CUNY hasn't done it;

Finally, adjustment in policies on absence and sick leave so that such policies will cease to be a disincentive for faculty, staff, and students who may be afflicted by the disease to take the single most important measure for public health, self isolation.

The Professional Staff Congress CUNY stands ready to assist the university in meeting its responsibility in any way we can.

We offer today's testimony in a spirit of protecting public health and

ensuring CUNY's compliance with its contractual obligations to provide a safe and healthy workplace.

We hope that today's testimony will stimulate CUNY at last to take the necessary action. Everyone in the university has a stake in CUNY's success.

Thank you very much.

CHAIRMAN GOTTFRIED: Thank you.

ASSEMBLYWOMAN GLICK: I just want to thank you for testifying today. What is always true at all of these hearings is that you hear at least two sides to the story, if not more. And I appreciate those issues that you raise. I think it's probably true across many campuses, not just in the CUNY system, but elsewhere where there could be dramatic improvements in just basic

sanitation, which apparently is also true in hospitals in view of the level infection rates, et cetera, that, you know, manage to scare one half to death when one's perfectly healthy. So we will take these concerns to the administration.

MS. BOWEN: Thank you. And I would say in Mr. Apsan's testimony, he didn't provide specifics. He said, well, we

are posting signs everywhere. In fact, if you actually look at campuses, the signs are not everywhere. There's not even hot water. There's not soap.

So with the lack of specifics in his testimony, it was difficult to judge whether he was asserting the level of detail, the kind of compliance that he spoke about, but I can tell you from the physical reports on the campuses, there isn't that compliance, and that's very disturbing, but equally disturbing is the lack of a heightened plan that would take into account that CUNY is a university and a very crowded university. Thank you.

CHAIRMAN GOTTFRIED: I think that part of the lesson here is that when we put institutions on prolonged inadequate financial resources, corners begin to get cut.

I mean, we went through this with our transit system for several decades. You know, it's easy to say, I suppose, you know, our budget is tight, you know, we'll fix the hot water in the building next year so the kids will wash their hands with cold water,

let alone the hygiene requirements of bathrooms during "ordinary times," when you get a situation like this, it makes the shortages of hot water, of adequate personnel to be able to do the wiping of frequently touched surfaces when you need to do that.

I mean, it probably is mind-boggling to the CUNY financial people to think how they would implement such a regimen at this point given their prolonged short financial leash that they've been on for lord knows how many years or decades.

And circumstances like this often remind us of the consequences of this kind of budgetary tightness.

MS. BOWEN: I agree with you complete and probably the next time I testify in front of you it will be about turning back proposed cuts, further cuts, to CUNY's budget. There's a $53 million cut on the offing right now. I think you're right, that you can't put an institution in a poverty situation for decades, and then expect it to be in a strong position to deal with any emergency.

On the other hand, not everything

they spoke about today is budgetary. That's my point. Some of it requires resources. Some of it requires commitment and focus and not simply saying, oh, we put signs up, but actually going around to the campuses, as our faculty and staff did and looking, are those signs up? Is there soap? I mean, something as simple as that. So some of it requires simply a commitment to the issue and not a sort of bare-minimum approach.

Also, an understanding of what it is to be a university and why the public university, like the public schools, needs a special protocol, not just the minimum one-size-fits-all from the City Health Department. CUNY needs a special protocol that speaks to the fact that it is a place with thousands of people from the public, and thousands -- 97,000 people in the target age group, and in especially an overcrowded mode right now.

So all of those things can be addressed, but not every single one requires a budgetary infusion such as the sick leave policy. I mean, there are things that can be done without a budgetary infusion. So

while I agree totally with you, and would be the -- with regard to the enforced poverty of CUNY, for decades, the planned poverty of CUNY, I also think that this issue can be addressed, at least initially, through some administrative umph and focus.

ASSEMBLYWOMAN GLICK: Thank you very much.

CHAIRMAN GOTTFRIED: Thank you.

ASSEMBLYMAN LANCMAN: I just want to make an observation. May I?

CHAIRMAN GOTTFRIED: Sure.

ASSEMBLYMAN LANCMAN: Just an observation, and I tried to raise this with the commissioner at the start of today's hearing which is, although healthcare workers are certainty the ones on the front of the front lines, there are many other occupations that have an increased risk of exposure to H1N1, and it's just so important for every government agency, or government entity, whether it's SUNY, CUNY or Department of Corrections, to analyze that particular workplace, and to identify the particular risks and come up with a strategy, and it sounds as if CUNY is lacking in that regard.

MS. BOWEN: In our view it is. And that's exactly the point. And every workplace is unique, obviously, but there are some, like corrections or transit, or others, that public schools and CUNY that

have a particular need to have heightened precautions because of their role with the public. So that's why we're here, and we do not think CUNY has risen to that level.

ASSEMBLYMAN LANCMAN: Thank you.

MS. BOWEN: Thank you very much.

CHAIRMAN GOTTFRIED: Thank you. Correction Officers Benevolent Association did not check in, so I am assuming that they are not here. So our next witness is Primary Care Development Corporation, Rhonda Kotelchuck.

(The witness was sworn.)

MS. KOTELCHUCK: Okay. I want to thank the leadership of the Assembly here for the opportunity to testify about the role of primary care in preventing, treating, managing the H1N1 flu, what we hope is not a crisis.

I'm Rhonda Kotelchuck. I'm the executive director of the Primary Care

Development Corporation, and as I said, I'm here to talk about primary care preparedness for H1N1.

We're the largest nonprofit specializing in primary care. We do two things. We act to expand primary care capacity and we act to improve it in low-income communities in New York State and elsewhere. We work very closely with the New York State Health Department and the New York City Health Department, as well as the state legislature and the City Council in these activities.

I'm going to skip our accomplishments in the interest of time. I know that Assemblyman Gottfried is aware of them and we have a very proud track record. I will go directly to primary care where very often people do not consider primary care providers as a major player in an emergency.

The fact is that they are the front line for the flu pandemic, and must be prepared to vaccinate and treat large numbers of people while also meeting regular primary care needs of their patients.

Over the last five years, with

financial support from the New York City Council, PCDC developed and implemented an emergency preparedness program to help primary care providers respond immediately and effectively in the event of an emergency. In fact, any kind of emergency.

Through this program, we've trained more than 2,000 health workers at 70 health centers across New York City, and those centers collectively serve about half a million New York City residents.

Having gone through intensive training and drills, including flu surge drills in many cases, these health centers are now among the most prepared in the country to respond.

While no one knows what to expect in the coming weeks, these health centers are ready to respond, ready to vaccinate, and treat patients and staff, accommodate and increase patient load, help prevent overcrowding in our emergency rooms. They're able to rapidly mobilize their staff in emergencies, and those staff work within

an emergency command structure that helps ensure precious resources are used effectively.

18 of these sites will act as crucial points of distribution to vaccinate as many people as possible on a given day. These sites are able to accommodate surges in patient volume, quickly and efficiently diagnose and triage an influx of patients, survey, track and report patient data, such as increases in the number of patients, severity of symptoms, underlying risk factors, and patient demographics, and provide culturally relevant information to the diverse communities that they serve.

They also have built strong links with community partners including the local response agencies, hospitals, places of worship, local elected officials, and community boards.

This preparation will play an important role in public health response to the flu pandemic. With increased capacity, health centers are prepared to be able to

see more patients in a community-based setting. This means fewer patients flooding our emergency rooms without true emergencies.

This was a major issue in the city last year when thousands of worried well or patients with mild symptoms flooded the emergency rooms instead of consulting with their primary care physicians.

Over the last few months, PCDC began working with the State Health Department to prepare primary care centers throughout the state for the flu pandemic. Through webinars and one-on-one coaching, we're helping these centers evaluate their operational efficiency, use staff and resources creatively to accommodate a surge in patient volume that'll associated with H1N1.

We are now increasingly be called on to help networks of primary care providers around the country in a similar fashion. This work is important and will let these health centers -- and will give

these health centers a level of preparedness they did not have before. However, it is no

substitute for the kind of intensive program we've been able to do here in New York State.

The underlying assumption of emergency preparedness is that there's enough primary care capacity in non-emergency situations. All of the preparation in the world can't ready a system that is too small and underfunded to meet the needs of the public.

New York has long underinvested in primary care. This has begun to change over the last several years as Governor Paterson and the New York State Legislature have made substantial investments in the primary care infrastructure including capital, increases in Medicaid reimbursement and indigent care payments and incentives to increase access, like extending office hours.

We have a long way to go, however. Visits to safety net providers are

soaring as more people lose their jobs and their health insurance, and these providers are hard pressed to keep up with demand.

The Common Wealth Fund recently came out with a score card that showed New

York to be dead list in the nation in avoidable hospital use and cost. It showed us to be dead last in emergency room waiting times which average four hours, even when it's not a flu emergency.

These are all clear symptoms of a primary system that's unable to meet the primary care needs of a population under normal circumstances, let alone a health emergency.

If a flu season is as bad as many health experts believe, New York's already taxed primary care providers and its ERs may both find themselves overwhelmed and unable to treat a greatly increased patient load.

That is why our recommendations for action go hand in hand. Number one, we strongly recommend that basic primary care emergency preparedness program be

implemented for centers throughout New York State. That way, New York State's primary care infrastructure will be more fully prepared for the next emergency, whether it be a flu pandemic, a blackout, a blizzard or other crisis.

Secondly, New York should

continue to invest heavily and rapidly in expansion of its primary care infrastructure. This is crucial to protect the public's health in emergencies and in non-emergencies.

We will be monitoring the situation closely to see how well New York's primary care system responds to this crisis and remain ready to work with the executive and the legislature on actions that will strengthen New York's primary care infrastructure and it's ability to respond in emergencies.

I very much appreciate this opportunity to share those comments with you.

CHAIRMAN GOTTFRIED: Thank you.

A question that I would have asked Dr. Baxter from Ryan except he clearly was much more focused on the clinical side of the operation than the business side, which I guess is what you want in a medical director.

The idea of essentially encouraging walk-ins to go to their community health center for their flu shot, I suppose the optimistic view of that from a

community health center viewpoint would be, oh, great, new people will come see what I wonderful place we have here and they'll come back as permanent patients.

The downside is, they'll come in and get their flu shot, we won't charge them for it, and we'll probably never see them again.

Is it too early to tell which of those views will dominate in terms of actual experience?

MS. KOTELCHUCK: Well, we're in very close touch with those 70 centers that we put through this intensive training over

the last five years. We did POD training. We through out the net to those that we thought were best positioned. We ended up training 18. We had a response by over 40 health centers. We opened it up so that people could come, or centers could come, even if they weren't designated as a POD.

And I think, as I talk with those players, overwhelmingly, I mean, they have to run a business, they have to meet their bottom line. Of course they want permanent patients, but they are mission driven and

they're going to do the right thing. That means they want to serve their communities, they want to be prepared, yes, they will need financial assistance, you know, in any way we can to offset the costs that they're likely to undertake.

You heard Dr. Baxter say, we are very pressed financially. This is a very difficult time for health centers but they're going to do the right thing and believe that they will have the support there necessary to, you know, when they need

it.

CHAIRMAN GOTTFRIED: Okay.

MS. KOTELCHUCK: I don't know if I answered your question.

CHAIRMAN GOTTFRIED: Well, it sounds to me like it may or may not bring them new permanent patients, but either way they're ready to do the job.

MS. KOTELCHUCK: It's the right thing to do and these are people from their communities who are connected in one way or another. Thank you very much.

CHAIRMAN GOTTFRIED: Thank you.

The next couple of groups on the list also did not check in which brings us

now to the New York Academy of Medicine.

(The witnesses were sworn.)

DR. OMPAD: Good afternoon. My name is Danielle Ompad. I am the associate director of the Center for Urban Epidemiologic Studies at the New York Academy of Medicine, and I'm an epidemiologist by training, and I'm here with my colleague.

MS. BOND: Hello. My name is Keosha Bond and I'm the project manager for the Center for Urban Epidemiology Studies at the New York Academy of Medicine.

Today I would like to thank you for the opportunity to discuss the H1N1 and influenza vaccination. On behalf of the New York Academy of Medicine, we appreciate the Assembly's interest in the issue which has been the subject of important research at NYAM and has led NYAM to directly engage our local community to increasing immunization coverage.

The New York Academy of Medicine, founded in 1847, is an independent, non-profit which uses research, education, community engagement, and evidence based

advocacy to improve the health of people living in the cities, especially disadvantaged and vulnerable populations.

The impacts of these initiatives reaches into neighborhoods in New York City, across the nation and around the world. Immunization reduction reduces illness that

results from influenza and respiratory tract infections that result from the underlying influenza. Seasonal influenza immunization rates among the elderly, the population that accounts for 90 percent of influenza-related deaths, rose steadily for a number of years. It has now leveled off between 50 and 70 percent. In New York City, the Department of Health and Mental Hygiene reported a 2007 city-wide immunization rate of 54.7 for adults aged 65 or older.

Efforts to increase vaccination rates have historically targeted individuals at high risk for complications due to influenza, including the elderly and those with certain chronic health conditions.

Despite the recommendations from the Advisory Committee on Immunization Practices, vaccination coverage among populations at high risk for complications

from influenza, like older people and those with heart and lung conditions have been generally low.

We systematically reviewed 56

studies published between 1990 and 2006 evaluating programs in different settings from within medical settings to venue-based and community approaches, in an effort to identify programs that successfully increase immunization rates.

Interventions that increased vaccination coverage to the health people 2010 goals include advertising, provider and patient mailings, registry-based telephone calls, patient and staff education, standing orders coupled with standardized forms, targeting syringe exchange customers and visiting nurses.

Most studies examined vaccination within the content of primary care setting or large scale regional program. In short, these programs target people already connected to the healthcare system. An important limitation of these types of approaches is their inability to reach those people who are not engaged in the healthcare

system.

Data from several sources,

including the National Health Interview Study, suggest that immunization rates are lower in racial/ethnic minority groups than whites, a disparity that exists for all age groups including elderly persons covered by Medicare and populations specifically targeted by public health interventions.

A particular concern is what is known as "hard to reach population." While no uniform definition of hard to reach population exists, hard to reach populations have typically been defined from the perspective of the absence of regular linkage with the healthcare system. Although data is limited, hard to reach population groups such as housebound elderly, disenfranchised groups, people living in disadvantaged communities, undocumented immigrants, substance users may be less likely than individuals receiving routine healthcare services to receive influenza immunization.

In light of the data available addressing vaccine access for this

population, we at NYAM sought to fill this gap. The Harlem Community and Academic Partnership, a network of community-based organizations and health leaders affiliated with NYAM carried out Project VIVA, which stands for Venue Intensive Vaccines for Adults. Project VIVA was a set of intervention activities aimed to increasing acceptance of influenza vaccination among hard to reach populations in East Harlem and the Bronx.

Activities targeted the individual, community organization, and neighborhood levels, and included disseminating project information, presentations at community meetings, providing street base and door-to-door vaccination during the two influenza seasons.

Essentially we hired outreach workers from the community and trained them to deliver information about the flu vaccine to the community. A key aspect of the intervention was our uniforms which is a

bright yellow jacket with our logo. The more time we spent in the community talking to people about influenza vaccination, the more recognizable we became. We also attended community meetings and distributed more than 100,000 promotional flyers, vaccination myth cartoons, vaccine influenza information sheets, and 2,200 vaccine doses.

Project VIVA increased interest in receiving influenza vaccine post-intervention and distributed vaccine in the community. At one point, we had a line around the block at the Pathmark on 125th Street and Lexington Avenue. Individuals living in the intervention neighborhoods were more interested in receiving influenza vaccine compared to their interests before the intervention.

DR. OMPAD: Community participation and leadership was really critical to the success of project VIVA. Specific factors that contributed to the success of the rapid vaccination intervention included community members

leading the planning and implementation of

the intervention, extensive outreach activities, the selection of staff with personal knowledge of the project neighborhoods, and the readily recognizable project staff wearing their yellow jackets and consistently wearing those yellow jackets.

These factors allowed us to gain access to populations unlikely to report to private or government sponsored health clinics to receive immunizations, and our findings demonstrate the feasibility of delivering vaccines to members of hard to reach populations in non-traditional urban settings through a framework of community-based approaches.

We also learned that our target population was not hard to reach, but rather it was easy to miss if we don't walk outside our institutions and into the community. Given the research and the community work that we've done, NYAM recommends the Assembly consider providing grants to

community-based organizations and health providers to run targeted, culturally sensitive outreach programs with

easy-to-miss populations.

In addition, the Assembly and the Department of Health should consider providing support to allow existing health outreach programs to expand their services to provide vaccinations.

Our experience also told us that involving the community in the planning and execution of vaccine distribution is key. This is underscored in a special issue of the American Journal of Public Health that addresses influenza preparedness and response which is out this month.

We're co-authors on an article in that special issue which discussed the protection of racial and ethnic minority populations during the influenza pandemic and summarized in external partners meeting that happened at the CDC in 2008.

The stakeholders at this meeting suggest that "racial, ethnic minority

populations in communities must be fully included as partners in implementing all aspects of pandemic preparedness and response especially in planning, identifying needs and local resources, designing local policies and procedures, and responding

within their communities in a coordinated way. The same principles can and should be expanded more broadly to what we're calling easy-to-miss populations.

New York has taken important steps to increase vaccination rates and to prepare for a pandemic. The current H1N1 situation is testing these efforts and we applaud efforts to keep the public informed and calm while working to make vaccine available in a timely manner.

Efforts to expand immunization amongst the easy-to-miss populations will require creative and intensive efforts and must involve community organizations who can prepare for and promote vaccination in non-traditional settings and at times convenient to hard-to-reach populations.

Current strategies for vaccination all too often employ methods that are most comfortable for those who are providing the vaccine, giving little attention to the needs of those who are not connect to care. The easy-to-miss population cannot be ignored and the strategies we implement today and the

lessons we learn will be vital as this pandemic of influenza unfolds.

So let's talk about what we've seen so far in the season. The Department of Health has a tremendous challenge with updating the information to the public in a season where there are two viruses that affect different age groups. They have focused appropriately on the whole population of New York. The first efforts have been to educate. The second is to assure that healthcare workers get vaccinated so that they can take care of the sick. The third is to get people to go to their health care providers and thanks to the state legislator, last year pharmacists

became immunizers too.

The fourth phase is to attempt to provide vaccine to those without healthcare providers and who have limited resources to afford the vaccine. It is this final group where we believe plans need to be better refined.

As we know, vaccines do not come out all at once, but in batches. The poor and hard to reach are often at the end of the line. Traditionally, this group is also

at the end of the influenza vaccination season. This is true despite the fact that each year, at the end of the traditional flue season, thousands of doses are discarded even though many did not receive the vaccine. This happens even during years when there is a vaccine shortage.

There are community-based organizations that can be mobilized to work with clinicians to provide vaccines earlier in the system as a way to expand the capacity of the system.

We, as New Yorkers, need to

mobilize this capacity and reach those that have been easy to miss.

Thank you for the opportunity to testify and we look forward to any questions that you may have.

CHAIRMAN GOTTFRIED: Thank you. I like the terminology easy to miss as opposed to hard to reach.

I have a couple of questions about the project you ran. Were your people, when they knocked on doors or reached out to people, were they actually offering to administer the vaccine at

people's door, or referring them to sites where they could receive it?

MS. OMPAD: We actually did both. So in the first part of our efforts, we did outreach just to educate people and let them know that we were coming.

Then when we came, we brought vaccine, and we offered vaccination to those who were interested in getting right then, and if they decided that they weren't, then we gave them information for where they

could go to get it within the community.

CHAIRMAN GOTTFRIED: Which means that you had to have with you an RN?

MS. OMPAD: We had an RN. We worked -- for that project, we had outreach workers that took care of the paperwork and the RN that looked over the paperwork and then administered the vaccine. Then we also had oversight by physicians who were on our staff at the time.

CHAIRMAN GOTTFRIED: And if you think about replicating this, I would think the immediate thought would be cost per person vaccinated I guess, or some sort of measure of cost.

MS. OMPAD: We actually agree

because that -- what we realized is so -- in terms of proof of concept, we were able to go into the community and provide vaccine door to door or out on the corner of 125th, but in terms of sustainability, it's a little challenging in terms of funding.

So our second project that was funded by the National Center For Minority

Health and Health Disparities, is looking at ways that we can make it more sustainable. So we're working with community-based organizations and trying to partner with some other organizations to provide vaccines.

We're also looking to create a group of volunteer clinicians who would be able to potentially administer vaccine within these non-traditional settings which include nonmedical community-based organizations.

MS. BOND: Yes, we're connecting the vaccinators with the community at this time really by reaching out to the community organization that already served community members in different aspects, such as substance abuse, HIV prevention already, and

by doing this, we're trying to develop a model that can be used at other locations. Right now, we're focused on the east and central Harlem area and community-based organizations that we're working with so far are Paladia and Iris House at this time.

Once we evaluate our work and research, and we see how sustainable this model is, we'll be able to pass this on to other community organizations in an effort to increase influenza vaccination rates among this population.

CHAIRMAN GOTTFRIED: Okay. Questions?

ASSEMBLYMAN LANCMAN: Just in terms of the population we're talking about, a little bit off the beaten path, we haven't really talked about the concept of paid sick days. I imagine it would be very beneficial, or would imagine that many people are doing probably the worst thing they that they can do in terms of preventing H1N1 from spreading and that's showing up at work when they're sick.

Do you see a problem with the people that you serve where they do not have paid sick leave, and they're sick and

they've got to make a choice between showing up and toughing it out, or, you know, not getting fired or not paying rent that month?

DR. OMPAD: Well, the epidemiologist in me is going to tell you that we don't have data to support any of those observations.

ASSEMBLYMAN LANCMAN: But what does the person in you say?

DR. OMPAD: But, anecdotally, I would say a lot the people in our population don't have sick leave and they might work multiple jobs. We know through some of our studies that the people in our targeted communities are extremely impoverished. A lot of them report not having eaten in at least one day in the last six months because they couldn't afford to.

So we can all conceptualize how someone with multiple jobs is going to have to make the choice between eating, because they need to get paid, so they go to work versus not. That's not only an issue in terms of going to work sick, but that's also an issue in terms of trying to go to your healthcare provider to get a vaccine.

So if we can make it more easily

available, then we would be able to, once there was increase in uptake, reduce the number of sick days that people would need to take because of influenza, and then they would be able to feed their families.

CHAIRMAN GOTTFRIED: Thank you.

MS. OMPAD: Thank you.

MS. BOND: Thank you.

CHAIRMAN GOTTFRIED: Okay. New York Association of Healthcare Providers, are they still here? No. Then we will go to number 21, the Transport Workers Union? Is there someone here? Yes. Okay.

(The witness was sworn.)

MR. THORPE: Good afternoon, Assemblyman Lancman and Gottfried. Thank you for allowing us to present this testimony. I will read a statement on behalf of the Transport Workers Union Leadership, Current President Roger Trasant, and Acting President Curtis Tate.

My name is Vernon Thorpe and I'm a legislative liaison for the local.

As a union that represents 35,000

employees at the MTA, TW Local 100 has members in all aspects of subway and bus transportation.

More than half have daily on the job contact with riders. New York has, by far, the highest rate of public transportation use of any American city. More than 50 percent of our population commutes to school or to work every day.

In addition, New York is the only city in the United States where over half of all households do not own a car. I am presenting this data to illustrate how serious TWU Local 100 is when it comes to a pandemic influenza threat like the one we may face this winter.

Except for school and healthcare settings, there's no other place where so many people can simultaneously be exposed to the H1N1 and other flu viruses.

Local 100 has long been aware of the need to protect our members as an essential element in stopping the spread of this virus and throughout the city. For

months, we have been requesting that management produce an effective plan to protect workers and the public.

Initially we found that management was slow to respond. After extensive correspondence and meetings, in September, the New York City Transit Authority, Office of City Safety, issued a policy instruction, or PI document, and you should have it in your appendix, Appendix A, to cover many of our concerns, including some improvements produced in response to our request.

In brief, the policy instruction establishes responsibility for all aspects of the pandemic plan, it requires that all alcohol cleansers be provided to most workers who have contact with the public in the course of work. It makes surface wipes available to workers with shared work areas and equipment such as buses and offices to wipe down work surfaces at the beginning of each shift. It also sets up a vaccination plan for general flu vaccination and H1N1

vaccine to be provided when it becomes available.

Despite what we've accomplished, we have faced problems along the way. Management has responded quickly to address some concerns but others remain. Some of the problems are, distribution of materials has been haphazard and flawed. Such as, starting on October 1st, cleanser and surface wipe packets were handed out to workers recognized to have public contact, but no training or information was provided to those workers.

Gloves were given out without additional material explaining that they are to be used with the surface wipes. Management combined the surface and the hand cleansers increasing the possibility that people would use them incorrectly.

Management's proposed vaccination schedule doesn't cover all shifts, and not all titles with shared work surfaces are exposed to the public are adequately covered in the pandemic plan.

Management's eventual responsiveness was a positive development. However, in our comments, we requested labor participation in all steps of their plan,

and that commitment was included in their policy instruction.

They have responded to several immediate concerns, but we want to stress the constant monitoring of management's actions is necessary, and this is what has led to improved policy and practice at the New York City Transit Authority.

Local 100 continues to assess the distribution and use of cleaning materials to monitor reports of illness in our members and to make sure that worker's contractual rights are not impinged upon.

However, the fact remains that the published policy instruction does not address essential concerns about operations and sick leave policy. For example, although each division is tasked with planning for extended absenteeism, no written plan has been submitted. And there

is, as yet, no open discussion about how sick leave rules might be modified or waived in an emergency such as this.

Human resource's response to our request for a clear policy was that it's not yet time to develop a specific policy or instruction to address sick leave and other

labor issues in case of a pandemic, but that they will work in a cooperative manner with TWU Local 100 when this becomes necessary.

We are concerned that this may leave the matter until too late from the standpoint of both treating transit workers humanely and keeping mass transit humming and also protecting the ridership.

Local 100 has been very active in this process but none of our requests are original. The outlines of an effective pandemic plan, adapted for transportation employers, was published some years ago, and are wildly disseminated by the CDC, the Department of Transportation and the Department of Homeland Security. OSHA has added specific guidelines for cleaning areas

of known H1N1 exposure in transportation and trucking. We used all of these as our guides. The CDC general guidelines for employers aided Local 100 in developing its own pandemic flu plan for Union staff and elected officers.

We will keep pushing MTA to do what is right and necessary to stop the spread of the virus among our members as

well as among New York residents. We are in sympathy with all unions attempting to win a clear commitment from management regarding sick leave policies that don't penalize workers if they get sick themselves, or if they must say stay home to take care of family members. Keeping New York moving in a safe, healthy, and fair way is our goal.

Thank you.

CHAIRMAN GOTTFRIED: Thank you.

To what extent was the union consulted in the development of the Transit Authority Plan? You talked about what sounded like post plan consultation?

MR. THORPE: Yes. I couldn't

give you the details. The people who are normally here are not present, as you can see but, as far as I know, they went ahead and began to implement their own plan, but it wasn't really a plan, it was a set of policy instructions from management, and then we found about it and began to tell them that they needed to make changes, necessary changes. So we basically pushed them to do what was required, which is always the case.

ASSEMBLYMAN LANCMAN: So what

specific sick leave policies would you like to see the MTA have in place?

MR. THORPE: Well, right now, as far as I know, there is no policy. If someone were to get sick, there's no policy instruction on how to handle someone with the H1N1. It would be a different situation. The person would become ill and it really hasn't -- a policy hasn't been written up to handle that situation. It's not like a normal sick day.

ASSEMBLYMAN LANCMAN: I assume

the MTA employees have a certain number of sick days per year.

MR. THORPE: They do, but this would be different.

ASSEMBLYMAN LANCMAN: Once you burn through your sick days, what happens if you're still sick?

MR. THORPE: Once you burn through your sick days, you deal with your vacation time -- actually, you can take a leave of absence. You can take -- it's called a policy whereby -- I forgot the name of it.

ASSEMBLYMAN LANCMAN: It's an

unpaid leave of absence?

MR. THORPE: Yes, it's an unpaid leave of absence. It's family medical leave. You can take that.

ASSEMBLYMAN LANCMAN: Which is unpaid?

MR. THORPE: Right. But they don't have a policy yet for this and H1N1.

ASSEMBLYMAN LANCMAN: Okay.

CHAIRMAN GOTTFRIED: Next is the

International Brotherhood of Teamsters.

(The witness was sworn.)

MS. STEIN: Good afternoon. My name is Diane Stein and I am the Safety and Health Coordinator for Teamsters Union, Local 237. I am here representing our president, Gregory Floyd.

We appreciate the opportunity to testify before you today to describe the variety of concerns our members have regarding the H1N1 virus, and the protections needed at their work sites.

Even though we're teamsters, we're actually not truckers. Local 237 represents more than 21,000 workers in New York City agencies and the New York City Housing Authority. Approximately 1,700 of

these workers are employed by the New York City Health and Hospitals Corporation.

Thousands of others of our members work in public schools, homeless shelters, juvenile justice facilities, correctional facilities, and other locations that put them in close contact with the

general public throughout their work day.

My gift to all of us is that I'm going to cut my testimony short in regard to the mandatory flu vaccine. We don't like it.

ASSEMBLYMAN LANCMAN: Let that serve as a model going forward.

MS. STEIN: Having said that, I just want to tell a very brief story about a phone call I got, however, late Friday afternoon. I got a call from a distraught member who works in an HHC facility who said that her aunt had died following the flu vaccine in the 1970s and she was really distraught about having to take the vaccine now.

The reason I tell you this, besides the obvious distress that she was under is that, it was clear in my

conversation with her, because of mandation, nobody in the facility was taking the time to talk to people about why they should have the vaccine, what the risks were, they just got the letter saying, get it by November

30th or you're fired, and I think that that's one of the other problems with mandation.

As Assemblyman Lancman pointed out a couple minutes ago, H1N1 is not just a healthcare worker issue. At the same time we were receiving dozens of calls from the healthcare workers union, our leadership was also receiving, and is receiving, dozens of calls each week from workers in other settings in which workers would like to get a vaccine but they're not sure where to get it, whether they're allowed to do it on work time, how they can prevent their own possible flu episode.

To illustrate the source of the concern, it's important to note that my union, Local 237, represents 4,500 school safety agents. Last spring, when New York City shut down dozens of schools because of H1N1, our safety agents were among the few staff that were kept in their locations in

the shut-down schools. We had several reports of safety agents in those schools

suffering flu-like illnesses, including several cases of symptoms severe enough that they required trips to the hospital. And now they're just trying to figure out how they can be protected on the job.

The unifying thread of these two different sets of circumstances is that they both illustrate the lack of good occupational health practices in the agencies concerning the prevention of the flu, and also lack of good infection control.

The New York City Health Department testified earlier that they're putting together a robust public health campaign to prevent the spread of flu in our city. What's lacking is evidence of a similar commitment to protecting workers on the job.

Several unions, including Local 237, have been meeting with the City Office of Labor Relations to try to work with them on a comprehensive infection control program in New York City workplaces. And to answer

the question that you just asked the brother from the Transit Workers, we were not involved in the beginning, they had a plan, and we're looking at it now. I presume DC-37 will talk about that as well.

In a communication from the New York City Office of Labor Relations from October 5th, just a week ago, a variety of the city's recommendations are based on designating the current flu as "a mild to moderate scenario."

This is in direct contradiction to Dr. Thomas Friedan, the current director of CDC, and the former commissioner of the New York City Department of Health, who said that this flu should never be characterized as a mild disease.

The reason that's important is that they stepped up leave policies if it becomes a severe epidemic, rather than what they're calling mild to moderate, so it has real policy implications.

We're not asking for anything extraordinary. Local 237, along with many

other unions that have been working in coalition on this issue, are simply asking that employers follow the New York State public employee safety and health guidelines and conduct risk assessments and, based on those risk assessments, institute protections for workers. And I'd just like to say that protections are not just vaccines and, while hand washing is important, it's not just hand washing.

There's one hospital in Queens where we represent the hospital police, and we have somebody stationed in the emergency room where hundreds of people are coming in, and they're sort of set back. If we put up a piece of Plexiglass, that would do it, that would be a good sneeze guard for them. They promised that to us months ago. Nothing's happened. It's a couple of hours of work for a maintenance worker, and that's one example of an alternate way to look at the risk, find a practical solution, and implement it.

In conclusion, Teamsters Local

237 urges you to do everything within your power to rescind the New York State Department of Health mandate of flu vaccines for workers in healthcare facilities; and, two, to help to expand the H1N1 efforts by working to ensure that all employers follow best practices of infection control for workers, including conducting task based risk assessments and instituting proper controls. Thank you.

CHAIRMAN GOTTFRIED: Thank you. Questions?

ASSEMBLYMAN LANCMAN: Yes. Can you testify as to whether or not HHC is, in fact, requiring every person, every employee in its facility from the top floor to the sub-basement to get vaccinated?

MS. STEIN: That's my understanding.

ASSEMBLYMAN LANCMAN: Do you know if HHC has, on the facility-wide basis or corporation-wide basis, done any kind of analysis to determine whether or not every employee meets the Department of Health's

criteria meaning that they have some kind of direct contact with the patient with H1N1 or

potentially H1N1, or direct contact with someone who does have direct contact?

MS. STEIN: My union sent out a mailing about a week ago to all of our members who work in HHC facilities in which I asked them, among other things, to tell me if any risk assessment had been conducted on their jobs, and I've heard back from many of them on other issues, but no one has reported that they've had the risk assessment.

ASSEMBLYMAN LANCMAN: The other thing is that, when we did our report, as all the health professionals know but we learned, you know, there are many different processes that agencies or employers should look to and go through and controls to protect against H1N1; administrative controls, engineering controls, personal protective equipment, et cetera.

There's been, at least in the healthcare community, there's been such a

focus on mandatory vaccination that it seems like these other controls have fallen by the wayside. I mean, I haven't really heard a satisfactory explanation for why, in terms of personal protective equipment, the N95

respirator shouldn't be used in accordance with the CDC's guidelines and where the State Department of health came up with this other concept, and then to hear that certain engineering controls like the Plexiglass, et cetera, are not being implemented is troubling.

I, in coordination with the chair, and the other chairs of the committees, am probably going to write to HHC and ask for an explanation. I'm disappointed that they didn't come and testify here. If you could very quickly accumulate all the issues that you have in terms of HHC's not really addressing the things that it can be doing to prevent the spread of H1N1, that would be really really helpful.

MS. STEIN: Absolutely. Thank

you.

ASSEMBLYMAN LANCMAN: Thank you.

CHAIRMAN GOTTFRIED: Thank you.

Next we have Communication Workers of America.

(The witness was sworn.)

MS. SIEGEL de HERNANDEZ: Good

evening. My name is Micki Siegel de Hernandez. I'm the Health and Safety Director for the Communications Workers of America in District 1. We are the northeast district of CWA and we represent members in New York, New Jersey, and New England, and in New York alone, we represent 80,000 members.

It's a very diverse membership employed in telecommunications, higher education, manufacturing, broadcast cable, commercial printing newspapers, state, local, county government, airlines, and healthcare.

The reason that I bring that up is, as you mentioned, every single workplace poses very different risks and a whole

different plan needs to be developed which we have been busy at work doing.

I would like to focus my comments today on two specific topics; one is the mandatory vaccinations and, also, the response of New York City with regards to influenza preparedness and protection of workers in non-healthcare settings.

Like Diane, I will cut those initial comments short. CWA District 1 is

strongly opposed to the mandatory vaccinations. We are not opposed to flu vaccinations. We work with employers all the time to provide vaccinations on a voluntary basis in many different settings.

Our members are also dedicated health professionals who care very much about their work and their patients, and we resent the mischaracterization of workers who do not want to receive vaccinations as not caring about patients and as being selfish. Nothing could be further from the truth.

We believe that this vaccination,

this mandatory vaccination regulation has already failed in that it has created an unnecessary and dangerous backlash against immunizations. As a direct result of this regulation, we believe that we've lost the teachable moment that was created last spring when there was heightened concern about 2009 H1N1 during the outbreak.

It is also extremely unfortunate that the mandatory vaccination regulation has diverted attention from what we should be focusing on, a comprehensive worksite flu

preparedness program at every facility that includes thorough risk assessment, workplace practice and controls, adequate supplies of PPE, if needed, education, training, and non-punitive sick leave policies.

I just wanted to mention because this issue of sick leave has come up several times. Of course, people need paid sick leave, but many many employers also have punitive policies. Our members have sick leave in many different organizations, but if they take that sick leave, if they are

absent, they actually are punished, are disciplined, and stepped, which could eventually lead to termination.

So a voluntary flu vaccination should supplement but not supplant all of these other protections. If you don't take anything else away from this hearing today, I would like everybody to understand that when you have adequate workplace protections, supplemented by voluntary flu vaccinations, you can protect the workers and you can protect the patients. It is not one or the other as the New York State Department of Health seems to be implying.

I also wanted to mention that

making the influenza vaccinations a condition of employment, that all of our covered healthcare facilities have been backed into a corner. One by one, every single one of our members are being notified that if they are not vaccinated against seasonal and 2009 H1N1 influenza by November 30th, which is the deadline in the reg, they will be fired.

The only variation that we are seeing in these letters of notification from HHC to private facilities is possibly how long people will be suspended without pay before they will be fired. We do not believe that that should be the case obviously.

An additional problem, and, again, this was brought up in this hearing, is that several covered facilities have decided to extend the regulation to cover all personnel, whether or not these personnel may be exempt from the mandatory vaccination requirements because they do not have direct patient care, or they only have infrequent and/or incidental contact with others.

We believe that this is occurring in HHC and in other facilities because it's just easier. It easier to say everyone should get vaccinated rather than figure out who exactly should be covered.

I just wanted to read you briefly a fact from one of our hospitals which asks,

will all staff be required to participate? It says that some people are actually exempt, however, with the small number of staff that fit this category, it is believed that everyone would benefit by extending this regulation to apply to all staff and the policy has been amended accordingly. We are seeing this over and over again.

In addition, we are also starting to see notifications from hospitals, covered hospital facilities to other employers who enter those hospitals, like telecommunication, like construction companies, who enter those hospitals saying, we are now requiring that all of your employees show proof of vaccination if they will work in the hospital facilities, whether or not, again, whether or not they have contact with patients or with staff who have contact with patients.

Finally, any emergency regulation obviously should be based on a clear and undeniable need. The underlying assumption of this vaccination regulation is that there

is somehow an unacceptable level of flu transmission by healthcare workers to patients, and that by mandating vaccinations is the only way to correct the situation.

However, the regulatory impact statement of this regulation offers no substantial or direct evidence to support this. None. Zero. You can look through all the data that they have in there. None of that shows that this is essentially a problem. Coupled with the complete lack of attention being paid to appropriate workplace protections which can minimize or prevent the spread of seasonal and H1N1, this emergency regulation which will result in the firing of health care and other workers who do not want to be vaccinated is completely misguided and should be revoked.

With regard to New York City's H1N1 response New York City, the employer. During the outbreak in New York City this past spring, it became clear to CWA District

1 and other unions that New York City
agencies were not prepared to address the

outbreak, and that there was no apparent workplace flu preparedness plan for the city whatsoever.

This was in the midst of the schools being closed, the death of the assistant principal, outbreaks in correctional facilities, but agencies were making up policies on the fly and we were getting calls from our members.

So on May 29th, a meeting was held with the city at the request of DC-37 AFSCME to address the union's concerns. We were in attendance as was the teamsters, and the city agencies that were there was Office of Labor Relations, DCAS, COSH, and the Department of Health. The unions in attendance basically asked the city two questions. We asked, what kind of risk assessment had the city done to determine risk of exposure of employees, and what was the city's overall flu preparedness plan for city agencies and employees.

Now these are direct quotes. The city's response was, "There is no pandemic,

and it's business as usual." Obviously, this was completely unacceptable. The summer passed. We finally had a follow-up meeting with the same unions and the city on Monday, September 21st. The same agencies were represented with the addition of the Office of Emergency Management.

At this meeting, the unions were informed that OEM had been convening an Agency Steering Committee to develop an influenza health and safety plan for the city.

This IHASP, as they call it, would be a template to be used by each agency to develop agency specific influenza health and safety plans.

The unions were then informed that the IHASP, which was almost done, would be given to us in advance of workers, but that it was being rolled out that same Friday. We objected. They agreed that when the plan was complete, we would see it and there would be another joint meeting held a week later.

So first let me say that we support the goal of the IHASP, but we'd would like to point out some serious flaws in the plan. First, the city is only now beginning to address the H1N1 influenza outbreak, which we know hit the city hard last spring, and it's only now starting to work with agencies to figure out how employees may be exposed and what work practices and controls should be put into place to protect employees.

This planning should have occurred a long time ago. As a matter of fact, the timeline in their IHASP, which they are now starting to roll out to agencies gives the agencies six weeks to just determine who is going to be in charge and there is no date for when this plan has to be developed.

Secondly, the City's IHASP completely dismisses the role of airborne transmission of influenza, and it wrongly states that airborne transmission only occurs in hospitals during certain aerosol

generating procedures. This is just

factually untrue. This is not an academic discussion because if you do not accept the fact that there is airborne transmission, which is a fact, then you do not have to protect people against airborne transmission.

Lastly, the city, again, like the New York State Department of Health recommended surgical masks for respiratory protection rather than N-95 or higher respirators for employees who may be at high risk of exposure, and, again, surgical masks are not respirators. All of these items make the city's response to the H1N1 outbreak objectionable and inadequate in terms of employee protection.

So, in conclusion, we request the following. That the New York State Department of Health emergency regulation mandating vaccinations as a condition of employment for personnel in covered healthcare facilities should be immediately rescinded. There should be a statewide

effort to ensure all healthcare facilities implement comprehensive work site flu preparedness programs to protect workers and

patients alike.

All employers should develop and implement a flu preparedness program to protect their employee based upon the jobs performed and the risks of exposure and should include the elements that I have listed in the testimony, and, lastly, New York City should revise its influenza health and safety plan to address all modes of influenza transmission in the workplace, adequately address employee exposure risks, and recommend the appropriate respirators based upon risk of exposure.

Thank you.

CHAIRMAN GOTTFRIED: Thank you.

ASSEMBLYMAN LANCMAN: I'm just curious, what's your impression, satisfaction level with the non-governmental employers who you -- I mean, CWA represents a number of employees.

MS. SIEGEL de HERNANDEZ: Many

employees.

ASSEMBLYMAN LANCMAN: In private sector?

MS. SIEGEL de HERNANDEZ: Correct.

ASSEMBLYMAN LANCMAN: How are they doing?

MS. SIEGEL de HERNANDEZ: It depends on the employer. It really varies. We have been working with some of the telecommunication employers and, to their credit, at least one of them, one of the larger ones has actually been working on this issue for a couple of years now.

So we are still ironing out some of the details but they have identified critical employees, employees at high risk, whether it's somebody whose going into somebody's home to install equipment, or employees who work with close and frequent contact with the public or in crowded spaces. They have been stockpiling N95 respirators in the event that there is an outbreak that would warrant protection.

So they have been taking steps

and we are currently at the table actually working out the details. You know, again, some of our airlines, the FAA, it's a whole different regulatory issue, have not responded as appropriately.

ASSEMBLYMAN LANCMAN: Has OSHA, for the private sector employers, has OSHA been active in giving guidance and making

sure that employers know what to do or this is -- this is working where the employers themselves, together with the union, are sitting down and figuring out how do we protect our employees?

MS. SIEGEL de HERNANDEZ: Well, it's both, and actually there are several documents that OSHA has produced that have actually been available for quite some time in terms of workplace preparedness and what employers should be thinking about in terms of an overall flu preparedness program. There are documents about respiratory protection and what is appropriate and what is the difference between a respirator compared to a surgical mask.

Thank goodness we now have a head of OSHA who understands workplace health and safety and who has been supportive of those issues. You heard in earlier testimony that in a healthcare facility, a private healthcare facility in New York, there have already been OSHA citations for not providing the correct respiratory protection and protecting against the flu.

So OSHA does not then go into every single workplace unless, you know,

obviously they're called in for -- because of a complaint, so that's what our role is, is to make sure the employers of our members are doing what we think is the right thing, that we are involved in the discussions moving forward. Unfortunately there have been difficulties in terms of working with New York City in that regard.

ASSEMBLYMAN LANCMAN: Thank you.

CHAIRMAN GOTTFRIED: Thank you very much. The American Academy of Pediatrics, I believe is not here. Then next will be -- we have several DC-37 locals

who will be coming up together, 436, I guess DC-37 itself, 420, and 768.

UNIDENTIFIED SPEAKER: Local 420 and Local 436 had to leave to attend executive board meetings. They submitted written testimony, I believe.

(The witnesses were sworn.)

MR. REID: My name is Fitz Reid. I'm president of Local 768. I'm going to reduce what I had planned to say because Dr. Shufro said a whole lot and I do not want to repeat it. I'm just going to refer to three quotations from the letter of the

commissioner of the New York State Department of Health and just raise three questions. I raise three questions for the record.

One of them is, effect of the mandate. It really did not treat the workers as individuals, but it really treated the workers as machines. It dictates things for the workers without taking their consideration and puts their jobs at risk despite of what the CDC says

that whatever voluntary requirements there were should take into account federal laws and the workplace relationship.

The other thing I just want to say just as a number one point is that it put the burden on the worker. The worker has to take personal vaccination rather than workplace protection.

The second point we just like to make is that the U.S. Department of Health and Human Services give immunity to the production of this vaccine, the H1N1.

The second part about it, if they are to give immunity to the production, the distribution, and the implementation of this program, the workers are questioned, why do

we have to carry all this burden without any protection?

The third question that members really ask me is, what's the end, when will it end? If the State Department can just come in and say, just because you have this, you have to take this. When does it end if something new comes up, they can just make

another emergency regulation and there will be no end to it. What if this does not work? What if we need something else? What's the limit? They did not discuss anything with the unions in terms of that.

Just three other quotations, I know time is going, so I'm speaking a little bit quickly. I'm just quoting from the commissioner's letter dated September 24th, 2009. Just three quick quotations. The commissioner give credits to the workers. The early and uncertain months of what would become the HIV epidemic. In those first confused days of Anthrax attack, and when any new international traveler with a fever might have been carrying Sar's, you give credit to the workers. The workers have always been out there being exposed. If

fact, the health services workers are one of the workers who have the greatest exposure to diseases, infectious diseases, and other problems.

The second point I would just like to make quickly, from his letter is

that the same commissioner, letter September 24th, 2009, large numbers of people, quite clearly, would like to take the new H1N1 vaccine as soon as it is available, but it will be denied them the opportunity because they do not fall into the priority group.

Now the point he's saying is, look, because the hospital workers and the healthcare workers are getting the vaccine, they're going to do deny all the workers this. He continues to say, we don't mandate vaccination. Many ethnically troubling situations may occur. A healthcare worker, unconcerned about ordinary flu might refuse a routine seasonal vaccine, but then expect to be in the front of the line for the good stuff, the new and strictly rational swine flu vaccine.

Quick point I'm saying here, look at this one letter as a justification to giving people the influenza vaccine. The

vaccine was proposed by CDC on a voluntary basis. He makes it mandatory. After making it mandatory, he is challenging the worker

saying, you're getting an unfair advantage because you're in priority group and I'm making it mandatory to you. All the people want to get and they won't be able to get it because you have to get it.

The point I'm saying, he blames the workers for everything when he is the source of the problem and he's not being straight to the workers. He does not involves the worker's representative. He puts the workers' jobs on the line. On all of this, the workers are saying, this is unfair to us, this is when we are having a question about national care, when the cardinal question is, we do not want to make healthcare become mandatory for the bureaucrats and for the government.

Here, we are putting it on the workers and giving them tremendous amount of problem. Therefore, we're totally opposed to the mandate, the voluntary part about it. We are totally supportive of it, and we encourage the workers to do so.

25 MS. CLARKE: I'm Lee Clarke,

director of safety and health for District Council 37. I had submitted written testimony that started out as good morning. So I'll amend that and say good evening. Thank you for the opportunity to be here. I will not read my testimony because it has all been said throughout the course of the day especially by my brothers and sisters from the other unions that testified earlier.

However, I will say that -- District Council 37, first of all, represents more than 12,000 workers within Health and Hospitals Corporation and several thousand others in the Department of Health and Mental Health.

We want the State Commissioner of Health to withdraw those regulations, the mandatory vaccine regulations. It has had unintended consequences. It has made the members totally crazy. Totally crazy. You've heard all the reasons. Especially really really well articulated by Micki Siegel de Hernandez from CWA and Diane Stein

from the Teamsters.

My members feel very disrespected. Especially not only when the regulations came down mandating the vaccine, but when the Commissioner of Health promulgating his letter chastising healthcare workers and questioning their dedication and their professionalism. My members are under paid, overworked, and overly dedicated. To question their commitment to health care is insulting.

You cannot -- and this is a poorly thought out public health initiative that has back fired. Totally back fired. You have heard this morning, or the State DOH eluded to including the stakeholders in discussions. That has never happened. Never happened. District Council 37 is well, as well as the other unions who have testified here today never once, never once was invited to discuss our concerns regarding any pending regulation.

I would have loved to have seen the State Commissioner of Health here today

so that you could have questioned him as to why an emergency regulation was passed without a public health emergency being declared in the State of New York. That boggles my mind, but I feel confident in the fact that the New York civil liberties union was here and will probably be looking into that more thoroughly and I would certainly hope that your committees will do the same because that is really, I think, an abuse of power and that's very very frightening, not only for healthcare workers, but for every citizen in the State of New York.

The last time I saw something like this occur was when the World Trade Center towers fell, and we had worker protection agencies walking away from workers and rewriting -- picking and choosing the laws they wanted to follow, and throwing out the laws that they were supposed to follow, throw them right out the window. That's happening today. We have the City of New York picking and choosing what regulation to follow. They will follow

State DOH's mandate to vaccinate healthcare workers against their will, but they will

not follow the New York State Department of Labor's public employee's safety and health regulations that mandate that employers conduct a risk assessment and provide appropriate levels of respiratory protection. That boggles my mind and that makes no sense. We need to stop that so we do not have workers put at risk as they were during 9/11.

I'm glad that during the testimony today, it was pointed out that there are very clear differences between influenza vaccinations and MMWRs. One prevents disease, others may prevent it to some degree. There was some discussion about TB testing. That's testing. It's not a vaccination. Hepatitis B, which is offered to healthcare workers can be declined. Workers have a choice. Influenza vaccinations should also fall into that category.

I'm glad that everybody who

testified before me again today was able to, I heard the recurring refrain that there should be education and I am also happy that the committees here today clearly recognize

the need for good education of workers so that workers can make an informed choice which they cannot do because they're being forced to take the vaccine.

All that I could ask is, I hope that we can work together after these hearings are over to convince the Commissioner of Health, or mandate the Commissioner of Health to withdraw those regulations.

I really believe he's violating the law. I am not an attorney, but I think that our representatives which are you, my members who are your constituents, want you to really be there with us and get the Commissioner of Health to do the right thing which is show respect for the workers who put their lives on the line every day in the City of New York.

And, again, President Carmen

Charles from Local 420 had to attend an executive board meeting and had to leave. Her testimony is here. It was submitted earlier for the record.

CHAIRMAN GOTTFRIED: Did you want to ask a question?

ASSEMBLYMAN LANCMAN: Yes. I

should have asked the commissioner, the deputy commissioner was here this morning.

The regulation that's in place regarding the mandatory vaccination, that's an emergency regulation. Does that expire and does that need to be renewed and when is that and what is that --

MS. CLARKE: I'm really not sure. I believe the regulation mandates that all healthcare workers receive both vaccines by the 30th of November, so I would think that those regulations would expire. I really do not know.

But I do know if they do not expire, and if they're renewed again as an emergency regulation, without proper public input and stakeholder comment, workers --

healthcare workers would have to take both those vaccinations every year. Every year. It's not a one-shot deal.

ASSEMBLYMAN LANCMAN: I think people in the audience know. Someone is going to tell me and I'm going to say it later in the hearing, but before I let you go, I just want to confirm from what you have, just so the record is clear, it's your

understanding that HHC's policy is to vaccinate everyone in the HHC health facilities from top to bottom?

MS. CLARKE: What I can tell you is in, when we met with HHC, we asked them to -- what were their plans to identify workers based on their task that did not have to receive both vaccinations? The director, vice president of labor relations, said to all of the unions present in that room, that everybody has to take the vaccination. We gave her examples of workers who we believe should be exempt under the regulations.

The example that I gave her, what

about the -- "what about the high pressure plant sender who works in the boiler room and never sees the light of day?" Her response to the union's present there was, well, if he takes the elevator down to the basement, he very well may come in contact with a patient and therefore must take both vaccinations.

MR. REID: Just a quick response to your two questions. I'm reading from the -- may I go ahead?

CHAIRMAN GOTTFRIED: Yes.

MR. REID: The commissioner's letter dated August 26th. On August 13th, 2009, an emergency regulation went into effect which requires that all persons in certain healthcare settings receive annual vaccination against influenza by November 30 of each year.

So it's this emergency regulation which is a continuous process, and we're required these things for the first time, every year, in spite of what may be going on.

The other question about the HHC. From the President Allen D. Aviles' letter September 9, 2009, every HHC employee with limited exception must receive a seasonal flu shot. We asked him to define the exception and they could not really give us what the exception is, although they're using the same quote from the state, it was a very limited exception.

MS. CLARKE: So not only did we ask them about what steps they were taking to identify workers based on their task and patient contact would be exempt from the vaccination, they couldn't answer that.

We then went on to question them as to, when will they be conducting risk assessments so that they can take the proper steps to protect our members who do have patient contact from influenza. They haven't gotten around to that nor have they provided us with a date when they were ready to begin surveying their institutions.

So they're picking and choosing what regulation they want to follow, what's

convenient for them to follow, putting workers at risk, but also putting the burden on the workers of having to take vaccinations against their will.

CHAIRMAN GOTTFRIED: Just to try to clarify a little. The word emergency can refer to different things in different contexts. In the State Administrative Procedures Act, a regulation can be adopted quickly without the ordinary, sometimes several months time process for publication and public comment, where there is a need to issue it, and have it effective quickly.

If you are declaring a public emergency, that is based on a variety of different findings of, you know, danger to life and health and triggers all sorts of

authority to override laws and do other things that go far beyond simply the quick enactment of a regulation.

I think if we were asking the Health Department what the rational was for adopting the regulation on an emergency basis, I would assume they would point to

the fact that the world became aware of the H1N1 virus around late April, early May, and if a vaccine mandate were to be enacted, there was not a whole lot of time in which to -- from the time it became apparent that a vaccine was likely to be available to when you would want that being applied. So I think that would be their rationale for the rapid adoption of the regulation.

In terms of whether it is "temporary or not," I mean, I can only say that the regulation on its face says it takes effect immediately and reads in terms of being a permanent regulation on applying to, you know, annually, as you were saying.

A regulation that is adopted on an emergency basis then has to have a subsequent opportunity for people to comment. I don't have the State

Administrative Procedures Act in front of me, it may require the agency to reaffirm the regulation after the end of that comment period. I'm not sure.

MS. CLARKE: Respectfully,

assemblyman, I would say if the State Commissioner of Health were here, and he gave you that response, I would say that's just a dance in smoking mirrors. Because I believe earlier today the assistant commissioner, deputy commissioner said we were looking at this two years. I think that's on the record.

So to pass it as an emergency, thereby cutting off the public and stakeholders from having input and their say regarding this regulations is really disingenuous. It's wrong.

CHAIRMAN GOTTFRIED: Okay. Thank you very much. Next is CSEA, Local 818.

(The witness was sworn.)

MS. HIGGINS-HAVLICEK: Good evening. It's been a grueling day. My name is Bridgette Higgins-Havlick. I'm the president of the Local 818 CSEA in upstate New York, Fulton County.

Most importantly, what I'm going

to say is going to be redundant. You've heard almost all of this all day, but I'm

not that quick-witted to just improvise.

Thank you for the opportunity to speak before you today on behalf of CSEA. CSEA represents nearly 300,000 public and private sector workers in New York State, including 60,000 workers in healthcare facilities across the state.

I'm here today to voice my concerns and the concerns of my fellow workers from CSEA regarding the unfortunate way that New York State is addressing the H1N1 flu crisis.

I have been a registered professional home healthcare nurse for 17 years and currently work for Fulton County Certified Home Healthcare Agency.

It appears that all of the attention has been given to getting healthcare workers immunized to protect the health of their patients.

While mandating vaccinations for healthcare workers is controversial on its own, the effect and the morale and the retention of the affected workers does not

appear to have been considered. Many of whom are either threatening to quit if the mandate is enforced.

While the current emergency regulation provides an exemption for recognized medical contraindications, there is no allowance for an individual's religious or ethnical concerns. This may cause an additional crisis in an already strained healthcare system.

If many individuals are not allowed to serve due to these or other considerations, many individuals are also concerned about the quick approval of the vaccination by the FDA and wonder why New York is the only state to mandate vaccination in stark contrast to the direction being given by the nationally recognized experts at the Federal Department of Health and Human Services, and Centers for Disease Control who clearly state that the vaccination programs for both the H1N1 and the seasonal flu should be voluntary.

As healthcare providers, we deal

with life threatening contagious diseases on a daily basis. These diseases include tuberculosis, MRSA, Hepatitis B and C and HIV, among others, all which run rampant through the healthcare system.

For these diseases, we routinely use a range of universal precautions and, in doing so, have historically prevented the spread of infectious diseases and have successfully kept ourselves, and our families, and our patients healthy.

These universal precautions, which are the primary ways to protect the patients, have not been considered by the state to address this crisis. Those universal protections include, providing proper settings for patient treatment in hospitals like properly ventilated treatment rooms, having comprehensive emergency plans in place that provide for the designation of spaces to separate patients that show signs of the H1N1 flu, and to minimize their contact with staff and other patients and could be used for any disease outbreak;

Training and education of healthcare workers on proper disease control practices and the emergency plans for an H1N1 outbreak;

Provision of proper protective clothing including adequate respiratory protection of an N95 or better based on properly performed risk assessment to determine worker potential to be infected, and with the training needed to assure they're selected and correctly used;

Educating the public on the use of good personal hygiene practices;

The proper maintenance and cleaning of our healthcare facilities, which has been severely cut over the past several years.

At this time I would also like to relate the story of Rosemarie Kukys. Rosemarie is an RN with over 25 years experience and she works in the Orange County Nursing Home. Under the emergency regulation, her facility is exempt from mandatory vaccination requirements. Last

spring, a worker at her facility returned from a vacation in Mexico and became sick with flu-like symptoms.

Upon testing, it was determined that this individual had contracted Novel A/H1N1. Because the facility had a plan which included the education of residents, staff and families regarding proper hygiene, and the prompt availability of free Tamiflu as a prophylactic, the outbreak was controlled.

In summary, this crisis actually offers an opportunity for New York State to set a national example for the way to respond to an outbreak of serious disease threats. That example should be the establishment of a 21st Century infectious disease response plan that includes all weapons of our arsenal of infection control practices and is not a one-sided mandate that puts healthcare workers in jeopardy.

This situation can be likened to the struggle that occurred after the promulgation of the federal occupational

safety and health administrative bloodborne pathogen standard in December of 1991.

At that time, the naysayers said that the requirements of the progressive regulation could not be met, but over time

and with the determination, those in health care rose to the challenge and developed effective policies and procedures to protect healthcare workers from the threat of bloodborne diseases, and that is a result our efforts have seen these diseases effectively controlled in healthcare settings.

At this time, we have the same opportunity to take a quantum leap forward in the prevention and control of aerosol transmissible diseases or we can choose to live in the past.

As always the unions will lead the fight to provide comprehensive scientifically-based solutions for one of America's most important and endangered resources, the healthcare worker.

I am thankful for the opportunity

to present this information to the Assemblyperson's consideration.

As a state leads the nation in healthcare services, New York should be taking a comprehensive approach to the prevention of the H1N1 flu vaccination, or flu.

Just as an aside, working for

CHA, I work in the basement of the infirmary. Now as a CHA worker, as a home healthcare worker, I am mandated to have both vaccinations, however, the nurses and the healthcare workers that work in the infirmary directly in my same building are not mandated.

So this becomes a vital question to the director of public health as to who is mandated and who is not because, as a CHA worker, I am in and out of the building all day. I am in contact with the residents of the infirmary. I am in contact with the maintenance department, building department, with anyone else who comes in the office, and, clearly, the director of the county of

public health -- they have not written a policy yet as to who in my own building needs to be vaccinated.

So my point, as the president of the nurse's unit is, and I think everyone, most of the people in this room agree, is just to stop the mandation of the vaccinations and make it voluntary.

CHAIRMAN GOTTFRIED: The other workers in your building are of what sort

and for what agencies?

MS. HIGGINS-HAVLICEK: This would be an infirmary, a residential healthcare facility for the elderly. Those nurses, those healthcare workers are not mandated by this mandation to have either the flu or the H1N1 vaccination. Only CHA workers, hospice workers, but not infirmary workers.

CHAIRMAN GOTTFRIED: Right. I mean, for what its worth, legally, the reason for that distinction, is that several years ago we passed a law requiring nursing home workers to be offered flu vaccinations, but it was done on a voluntary basis and the

Health Department concluded, I think legally, correctly, that because of the existence of that statute, they were preempted from extending the mandate to nursing home workers, not that they wouldn't have wanted to.

MS. HIGGINS-HAVLICEK: Correct. But my point is we all work in the same building, and the public health director has not been able to clearly define who in the building, the maintenance workers, the cooks, you know, whomever I may come into contact with. I find it extremely unfair

that I'm being mandated and, in the same breath, my fellow nurses are not being mandated.

If you're going to mandate one, you need to mandate everybody, or you need to not mandate anybody.

CHAIRMAN GOTTFRIED: I think the Health Department would tell you that they tried pretty hard to get such a mandate applied to nursing home workers this past legislative session.

MS. HIGGINS-HAVLICEK: I'm sure they did.

CHAIRMAN GOTTFRIED: And it didn't quite get to the floor of either house.

MS. HIGGINS-HAVLICEK: But it did for us.

CHAIRMAN GOTTFRIED: Okay. Questions?

ASSEMBLYMAN LANCMAN: Just to clarify, just so you know who to be angry at, that was a regulation that the commissioner promulgated more or less on his own, not through legislation passed by the Assembly.

MS. HIGGINS-HAVLICEK: Well, I guess that that mandate really needs to be withdrawn.

CHAIRMAN GOTTFRIED: Thank you. Next we have several witnesses focused on the autism aspect of this topic. If they all want to come up together. I guess we five folks.

(The witnesses were sworn.)

CHAIRMAN GOTTFRIED: Who was the one who had to leave?

MR. GILMORE: Mary Holland.

MR. CONTE: If I may, John, she's given us a prepared statement, may I read it? Can we just submit it?

MR. GILMORE: I've incorporated a lot of Mary's testimony in mine.

Your staff contacted us, Mr. Gottfried, and asked us to sort of coordinate what we were saying to sort of avoid repetition and we've done that.

So I'm going to start off. My name is John Gilmore. I'm the Executive Director of the Autism Action Network, a national advocacy organization headquartered here in New York. I'm also the father of a nine-year-old boy who suffered extensive

brain damage as a result of a vaccine-induced encephalopathy at the age of 12 months. Like many children with vaccine-induced encephalopathy, he has a diagnosis of autism.

The first thing that I would like

to do is thank you, Mr. Gottfried and Mr. Lancman, for holding this hearing. Hearings such as this are extremely important in the democratic process, and that's one of the issues I want to get to a little bit later.

I'm joined here with several parents from other autism organizations. Several others also have vaccine injured children as well.

So you may recall, Mr. Gottfried, that I first met you several years ago in this very room at a hearing regarding Hepatitis B, and I brought up the issue of mercury content of that vaccine.

What spun from that was legislation passed in New York that limits the mercury content of vaccines and we were successful in this state. And one of the results from that legislation passed here in New York is that there are now, in any one

year, 50 million mercury-free doses of the flu shot available, as opposed to maybe six to eight million before the New York legislation was passed.

So, to some extent, given the situation we're in right now, I think it's safe to say that really the eyes of the United States are upon you, as it has been in the past.

Our main concern here is the mandate that Mr. Daines has seemed to put in place on over half a million healthcare workers who we believe are subject to the provisions.

We have a variety of concerns. First off, we don't believe this is actually a legal act. We don't believe that Commissioner Daines has the authority under New York Law to do what he claims he has authority to do.

We have several attorneys working on this. They have reviewed the sections of the Public Health Law that Commissioner Daines sited in his letter to the secretary of state, and we see nowhere in there any language that gives him the authority to do what he's done.

That is particularly true in the

situation that we have here where there seems to be no objective evidence of any kind to indicate that we are in an emergency situation when it comes to either seasonal flu, or the H1N1 virus.

I think the situation we're in right now happens when public health policy is made by headline and hysteria, rather than carefully considered facts and analysis.

Now some of the other concerns we have -- I'm going to address some of the concerns of both H1N1 and the seasonal flu. One of the concerns we have with the seasonal flu mandate is that it's not very effective. In some years, it's almost approaching an immeasurable effect. That happened in 2004. On a good year, you'll have a 50 percent effectiveness, and that's in the best scenario that the CDC can present.

And there's no reason to think that H1N1 is going to be any more effective than the seasonal flu because, what we're

basically seeing now, is that the H1N1 appears to be no more destructive than any other ordinary strain of flu that we deal with from year to year and, to support that, I think all we need to do is look what happened in the southern hemisphere in Australia this year.

Predictions were made that 10s of thousands, if not hundreds of thousands of people, would be dying in Chili and Argentina and South Africa, and that simply hasn't happened. In Australia, it's turned out to be a pretty average flu year, and I think that's exactly what we're going to see here in New York as flu season approaches.

Other concerns that we have about this is that, in this order, there's no exemptions for religious reasons. To our knowledge, I learned earlier I guess that there is no exemption for the MMR here in New York, I wasn't aware of that before today, but I know that for certain kinds of health workers, according to Section 2190 of the Public Health Law, certain healthcare

workers I think -- I'm not sure as to what definitions they apply to, are required to get a seasonal flu shot every year.

However, that's in Section 2190. At Section 2195, those same workers are given a religious exemption and they're also given an exemption for personal choice, which we think is exactly the way we need to do.

If you want to encourage people to take vaccines within a reasonable manner, that's fine, but at the end of the day, we believe it always has to be a situation of informed choice.

We're also concerned particularly given that probably the vast majority of healthcare workers in the United States are women, and primarily young women, that a very large portion of them are going to be in either in child-bearing years, and maybe pregnant or lactating, and this is going to bring us back to mercury. The vast majority of H1N1 shots out there have mercury in them. They have mercury in quantities that

is illegal to use in the State of New York

according to Section 2112.

However, Commissioner Daines has also issued a letter that it's okay with him if doctors use mercury containing vaccines in violation of New York Law as long as a doctor writes a letter that says they couldn't find the mercury-free ones.

I think what that does is sets up a situation where you're going to find pregnant women are going to be using the mercury-containing vaccines.

I know earlier today, Mr. Gottfried, you said that you ate a tuna fish sandwich and that that had more mercury in it than a flu shot would contain, and that's probably true, but you're a full grown man, you're not a fetus, I think that's an important distinction.

Another concern that hasn't been brought up today, and I think is a very important concern, is if somebody is injured by H1N1 vaccine, they basically have no recourse.

The Public Readiness and Emergency Preparedness Act of 2005 gave the manufacturers complete liability immunity, and it also gave immunity to any healthcare

workers that administer the shot.

And the H1N1 is also not covered by the Federal Vaccine Injuries Compensation Act. So if you are injured, and I think we're talking about half a million people getting a shot, if it goes that far, you're certainly going to have a certain number of people who are injured.

Another thing that wasn't mentioned today is the really horrible history of the swine flu from the 1970s. That shot we basically had another hysterical situation like we face now. Hundreds of thousands, maybe millions of people, got the swine flu shot then, and it turned out that the side-effects, deaths, and Guillian-Barre Syndrome that was caused, this is not contested that the vaccine caused this, that the vaccine itself was far worse than the swine flu in the 1970s.

So I imagine in a couple months, you may be having hearings about what to do with the healthcare workers who have been injured by H1N1 and have nowhere to turn to.

ASSEMBLYMAN LANCMAN: Let me ask you, what is your response to the Health

Department's response which is, that was a different vaccine?

MR. GILMORE: It is a different vaccine, but it's still, I would assume, and I'm not a vaccine expert, but it's still swine flu, and I'm assuming it may be the same antigen.

And another problem we have is that this version of the H1N1 has not been tested. We have very little data on it. If you take a look at the project -- the package insert, it says quite clearly that they have no idea how this is going to effect small children, pregnant women, or lactating women. And one of my colleagues is going to go into some detail about that later.

ASSEMBLYMAN LANCMAN: Do you have

a copy of that package?

MR. GILMORE: I can provide that to you. Sabeeha, do you have that?

ASSEMBLYMAN LANCMAN: Okay.

MR. GILMORE: Now there was also some confusion earlier today about what is actually in H1N1. Mr. Gottfried, you asked whether it contained squalene or not, and I think the person who was here wasn't

certain. I think that the cause of that is that there's been a great deal of confusion over the last few months about which version of the H1N1 would actually be marketed in the United States.

There's several dozen versions of it at this point coming from different countries and different formulations with and without squalene, with and without mercury. So there's a whole variety of different kinds coming out, and we were checking on this on a daily basis, and we didn't know which one was going to be until it was actually approved by the FDA.

So as far as I know from looking

at the CDC or the FDA side, there are no squalene containing H1N1s licensed in the United States right now.

CHAIRMAN GOTTFRIED: Thank you.

MR. GILMORE: Now one other concern I have, and this is the area I'm going to focus for the time I have left, and I'll try to be brief, is that we think the process here has been probably the worst way to make public policy I can possibly imagine.

We have three things going on from a vaccine or a medical drug perspective. We basically have three things in place to try and protect people from injury from a drug or a vaccine.

One is regulation, that has been circumvented at the federal level. Vaccine is coming out before we have adequately tested it.

The second protection is litigation. It's a standard of American juris prudence that if you're injured by someone, you can sue. You can't do that

here.

The third way to protect people is through informed consent and that has been removed as well. So the three pillars you have of protecting people from injury from any kind of medical device isn't in play when we're talking about H1N1.

I would always like to address how Commissioner Daines has managed the implementation of this law. First a little history. It seems that Commissioner Daines really has, I would say a deep disdain for the idea of informed choice. Commissioner Daines a couple of years ago at has request

had assembly bill 10-942 introduced. This was known in our world as the worst vaccine bill ever. It would have required all the citizens of New York if it had been passed to follow exactly the federally approved vaccine schedule without exception. This would not only apply to children in school, it would apply to children in preschool, and would apply to adults. That raises all kinds of questions. How was that -- were

records going to be kept on everybody? What was going to be done, and this was clearly, I think the Assembly in its wisdom, decided not to act upon this, so I thank you for doing that.

There's been other legislation I believe that Mr. Daines, the Department of Health, had Assembly Bill 8133 introduced. I believe what this bill would do, correct me if I'm wrong, Mr. Gottfried, is that it would make the seasonal flu mandatory for a certain subset of healthcare workers, but interestingly enough, what it does is it removes the personal choice exemption that is currently at Section 2195 of the Public Health Law. So basically what they're

seeking to do is make permanent this emergency procedure.

One other point I'd like to make is that one of the ideas I think behind mandatory vaccine laws is that there is a group of highly educated professionals that assume that they are better at assessing the risks and benefits of a particular vaccine

than other people.

But we are not talking about untrained people. We're talking about applying this law to physicians and highly experienced nurses. And I would defer to their judgment. I am sure there are many people who do not want to get this vaccine who are physicians, who are far more better judges of the efficacy and safety of this vaccine than Commissioner Daines is.

This assertion of mine is borne out by the data. The CDC has a program in place for years to try and increase the uptake of the seasonal flu shot amongst healthcare workers, and they never do better than 35 percent, and you have to ask yourself why.

There are also polls out there that show 50 percent of the physicians out

there have decided not to get the H1N1, and one of those physicians. He has announced that he will not get the vaccine.

CHAIRMAN GOTTFRIED: Actually, he said the opposite.

MR. GILMORE: That's not what I heard. That wasn't in the papers.

ASSEMBLYMAN LANCMAN: Well, I can't vouch for the accuracy of everything that you read in the papers, but Deputy Commissioner Birkhead said, and I can't quote him exactly, but I think the only lack of a firm yes on the part of the commissioner was as to whether -- he wanted to make sure that if and when he received an H1N1 vaccine, it was not in a circumstance in which there was a shortage of it for more high priority people.

But it was certainly not a lack of being vaccinated because of any concern about the vaccine.

MR. GILMORE: That's not what I was implying. I just think that it's probably not a wise management move to order people who answer to you to I think undergo a procedure that you are not quite

publically willing to do.

Now this is the way we basically see it. Now what we would like you to do.

There is a number of things that we would like the assembly to do.

First off, we would like you to pass some legislation. Two bills we would like you to pass is Assembly bill 880, and Assembly Bill 883. These are both Mr. Gottfried's bills. A 880 would basically let the decision of a physician who has determined that somebody may potentially be injured by a vaccine, would allow that decision to stand.

The practice in New York is that if a physician gives more than just a very few number of these exemptions, they will be investigated and their license challenged. Now I'll give a personal story. I have three MDs that have told me that my son was injured by a vaccine, and that they will not sign an exemption because they're worry about losing their licenses. This is very very common. I think if you ask my colleagues, they will have similar experience as well.

So, I think it's critical that

eight A-880 be passed. A883 would prevent these sort of religious tribunals, that some school districts convene to basically cross-examine parents about their religious beliefs when they request a religious exemption for a vaccine. We think that's necessary to pass as well.

The bill I mentioned earlier, Assembly Bill 8A-8133 that would basically remove the health care workers for personal choice exemption when it comes to seasonal flu vaccine. We think that needs to be defeated.

Assembly Member Mark Alessi has a Bill A-4886 A, this would provide the citizens of New York with a philosophical exemption to the school mandates for vaccines. 20 other states have this. So does Canada, England, Japan, most of the developed world, and half the American population lives in a state where they have this right, and we think it's far beyond time that the citizens of New York have this right as well.

There are a variety of bills that would add additional vaccines to the mandated schedule in New York. One would require Hepatitis A and another one would require HPV. We think these bills should just be ignored until they go away.

I think what's also abundantly clear at this point that we need a completely new piece of legislation that gives absolute total protection to the idea of informed consent. You should not have to take any kind of medical procedure to be employed in the State of New York, nor should you have to undergo a medical procedure against your best judgment or against a guardian's best judgment to attend school. This old style model of authoritarian public health procedures, implemented by coercion has to go. I think that this fiasco that Commissioner Daines has sort of descended upon the state is ample evidence of why that type of law is necessary. Thank you.

MR. CONTE: Thank you.

My name is Louis Conte, I'm the president of Autism Westchester and a member of the Autism Action Network, and the father of triplet boys aged nine, two with autism.

I disclose that I firmly believe that the vaccines were a trigger in the onset of regressive autism in two of my sons, Thomas and Sam.

My sons were affectionate, connected engaging infants, and after a round of vaccines at a well baby visit, they lost the ability to maintain eye contact. They became distant, detached, lost all ability to speak. I did call our pediatrician's office about my son's vaccine adverse reaction. I was never told about a thing called a vaccine adverse event reporting system. I didn't hear about it until I heard an interview with David Kerby on the Imus Show five years later. I was told that this reaction was typical, and, most interesting, I was told that I should not worry because vaccines do not cause autism.

I found this to be a strange comment because I was completely unaware

about the new controversy about vaccines and autism. A few months later, a child psychologist informed my wife and I that both of my sons had autism.

We are here today because of the actions of our health commissioner, and I think John did a great job in laying out how I think that there's been some overreaching here.

In divvying up the work of our panel, I was asked really to address three concerns, and the three concerns are, is there really a pandemic? And are the H1N1 vaccine and flu shots effective? And are the new H1N1 vaccines effective, and safety issues will be discussed by other panel members.

The first issue, is there a pandemic? I've heard the word "pandemic" thrown around a lot today. The World Health Organization has declared a flu pandemic. However, it should be noted that the World

Health Organization changed their definition of the word pandemic in May of this year.

The earlier version defined the term pandemic in this manner. An influenza pandemic occurs when a new influenza virus

appears against which the human population has no immunity, resulting in epidemics worldwide with enormous numbers of deaths and illnesses.

The new definition of pandemic was changed to, a disease epidemic occurs when there are more cases of that disease than normal. A pandemic is a worldwide epidemic of a disease. An influenza pandemic may occur when a new influenza virus appears against which the human population has no immunity.

You will note that the old requirement for massive numbers of deaths has been excused. This change was not announced to the media. The CDC tells us that 36,000 people die in the United States every year from flu. It is questionable whether this is actually accurate.

However, the impact of H1N1 flu is not anywhere near these numbers. According to Tom Jefferson, who is arguably one of the world's leading experts in influenza vaccines, a brief sidebar here, he worked for something called the Cochrane Collaborative, which is sort of the Pew

Institute, if you will, of medical research. They do a lot of research into various aspects of the medical world.

Dr. Tom Jefferson, an interesting name, has stated that the H1N1 flu is not a major threat. There's little evidence that flu vaccines are effective in preventing the flu, and this is a man who is a worldwide expert in the influenza vaccine.

He's authored "Ten Reviews of Research" on the influenza vaccine again for the Cochrane Collaboration. Jefferson notes that Australia has just completed its wintertime and there were 131 deaths related to the H1N1 flu this year. Australia has a population of 22 million.

So, if we are concerned about the

winter flu season in the U.S., we can simply look to the winter flu season in Australia as a predictor.

Are the H1N1 vaccine and flu shots effective? Jefferson's team asserted that, there is not enough evidence to decide whether routine vaccination to prevent influenza in healthy adults is effective. Jefferson's research confirmed that flu vaccination did slightly reduce the number

of adults experiencing confirmed influenza, but there was an increased number of adults experiencing influenza-like illnesses. It's symptoms are similar to the flu though are presumably caused by other viruses and not the flu viruses.

The bottom line is, the number of adults needing to go to the hospital, or take time off from work did not change between those adults receiving the flu vaccine, and those who did not.

In other words, analysis of flu vaccines, again, from the world's think tank in this matter, they show very little

efficacy in providing real health benefits. Why would you mandate a product that has no real effect.

CHAIRMAN GOTTFRIED: Excuse me, are you quoting from the Cochrane Collaborative document and is it distributed with your testimony?

MR. CONTE: Yes, assemblyman. I've given you the abstracts. The actual reports are quite lengthy, and I didn't want to -- you know. They are available. They're free on line. They can simply be

Googled.

Although the media commonly promotes the flu vaccine for children, Jefferson and his research group summarized their investigation on the subject by asserting, the national policies for the vaccination of healthy young children are based on very little evidence. They express strongest concern about the lack of efficacy in safety of flu vaccination of infants two years of age and under.

I have met several parents who

report to me that their children regressed into autism after flu vaccine. They did note that the flu vaccine is effective in reducing the flu in children over two years of age, but they found little evidence that the flu vaccine was even effective in reducing school absences.

Further, they found no convincing evidence that vaccines can reduce mortality, hospital admissions, serious complications, and community transmission of influenza.

Again, why would you mandate a product that has no real effect?

CHAIRMAN GOTTFRIED: Can I just ask -- well, no. Why don't you finish and

then I'll come back with a question later.

MR. CONTE: Jefferson was very concerned, and there's an interview that was done by an Italian correspondent that I've attached to what I've provided your committee. Jefferson was very concerned about the safety of the four FDA approved H1N1 vaccines. Dr. Jefferson expressed serious alarm about the evidence for the

safety and efficacy of these vaccines.

The study sample was tiny, 240 adults. The reassuring statements of the authors about Guillian-Barre Syndrome are illogical because Guillian-Barre occurs in one out of 750,000 to one million vaccinations. The population is simple, it's just too small.

One-third of the 240 people had side effects that resembled influenza-like illnesses, fever, headaches, sore throats, et cetera. In other words, they were vaccinating to prevent symptoms they were in fact causing.

There was no placebo arm of this study. And this is a problem because there are -- these are experimental vaccines and

there is no ethical excuse for not having the placebo group with a new product.

The types of vaccine additives in the H1N1 remain unclear. Actually, John did clarify some of the that, and I actually learned it while I was sitting here. We do know that thimerosal mercury is in the H1N1

vaccine, but its manufacturer has not clearly laid out whether adjuvants such as alluminum are in the vaccine. The product safety sheet for thimerosal strongly advises that it not be mixed with aluminum products. Why would we recommend giving this product to pregnant women and children over six months. And a quick sidebar about when aluminum and mercury are mixed together, they potentially have negative effects of both of those heavy metals in the vaccine.

You'll note that I have not really addressed, other than brief comments, vaccine safety issues. Other panels will cover that issue. However, I must ask why our state would mandate the use of these products for healthcare workers.

The information that we have from the Cochrane Collaboration indicates that we may be mandating these workers to take a

product that is not effective and that may, in fact, give them flu-like symptoms, when they might not have caught the actual flu to begin with.

Again, I'm not going to go near the issue of whether the vaccine is really safe. We do know these vaccines are experimental and we are carrying out an experiment on our healthcare workers.

In closing, I think it's time that we began to have more hearings on vaccines. In the past two weeks, very alarming research has come out about the Hepatitis B vaccine. One from the state facility, Stony Brook, which talked about the link between the Hepatitis B vaccine, a neuro-developmental disorders, and new research coming from Katherine Huwittson in Pittsburgh which raises real concern that the Hep B in a primate study does massive damage to the brain stem, particular when given within the first hours of life, as it in this state.

It's my opinion that you would be well served by holding hearings on the Hep B and that that vaccine should be pulled from

the mandatory schedule as well. Thank you.

MS. RUDLEY: Hi. My name is Lisa

Rudley. I want to begin by sharing with you my story. I'm a mother of three children. Two with vaccine injury and one of them is fully recovered. The other child is on the autistic spectrum, and has made significant gains through a special diet and to address his malabsorption issues and detoxification program to remove heavy metals and other toxins caused by the vaccines. I'm a holistic health practitioner consulting families in the tri-state area. At present, I have close to 400 families on my member list.

I'm here today to discuss vaccine choice and informed consent and to discuss the true nature of this pandemic with regards to outbreaks. First, let me state that vaccines are the only drug classification that has mandates as a requirement for schools and healthcare employment.

While childhood mandates in New York State can opt-out due to religious and medical exemptions, healthcare workers have

only limited medical exemptions available.

With every administration of a pharmaceutical drug taken orally, nasally or via injection comes a certain level of risk. It is undoubtedly accepted that H1N1 has had limited clinical trials. Many of the associated risks come from vaccinations in post-clinical trials, and clearly, in this instance, there will be inadequate time to evaluate this.

The healthcare workers, in particular, were notified only a short time ago that they must get their seasonal flu and H1N1 vaccinations, or they will lose their employment and possibly risk losing their licenses.

I've been independently asking many nurses, doctors, parents, school teachers, and teenagers their position on H1N1. And the majority have all said that they will not get the vaccination because they were concerned with safety, including my brother who is a physician in South Jersey.

There is a huge discrepancy by recommending pregnant women to get this H1N1 vaccination, and the documented unknown risk to the fetus. When the same vaccination is not recommended for infants under the age of six months old.

In fact, five years ago, when my doctor recommended that I get the flu vaccination when I was pregnant with my third child because of fear of the flu affecting me and my unborn child, he failed to tell me that that vaccine still had 25 micrograms of thimerosal mercury which is what the H1N1 vaccination has in it.

In addition, I debated a very prominent pediatrician named Dr. Amler in the Westchester area who has also worked for the CDC's toxicology department.

When I asked him -- actually, it was off the record. We debated on a webcast and off the record. I had asked him, I said, would you recommend a flu vaccine for a pregnant woman? And his first reaction was, no. And then he paused. And he said,

said, oh, well they recommend that vaccines, flu vaccines should be given at any time in pregnancy.

He concluded that he would at least wait until the third trimester, but he seemed even reluctant with that answer as he had an obligation to uphold the CDC's recommendation.

The bottom line is, that because of the potential risk, and we now know that temporary and permanent brain encephalopathy is not so uncommon with vaccinations. One should be given all the facts and a non-coercive informed consent to make the best possible decision.

When vaccinations are mandated, it removed a person's human right to informed consent. Vaccinations are the only facet of medicine where mandates are allowed and ultimately removes that informed consent. And informed consents allows patients to be made fully aware of all the ingredients and the risks associated with

this medicine. And, also, the ability to opt-out and say no.

I want to read just a statement

from Barbara Lowe Fischer. She is the president of the National Vaccine Information Center. And she states that, "Every day Americans wake up to the news reports that warn us about the dangers of influenza, especially the H1N1 swine flu. And the need to roll up our sleeves and get vaccinated. We are witnessing a rollout of the largest, most expensive mass vaccination campaign in the history of the nation. A rollout that is even bigger than the Polio vaccine campaigns of the 1950s. How much do we know that this disease or what the vaccine risks are, and if we can make an informed decision?"

Also, first, she stated that the swine flu and everybody has stated here today, is mild for most people, and the virus is not mutating to more serious form.

By the end of September, there had been 600 deaths in America, including 50

deaths in young children. Complications from infectious diseases like influenza are more common with heart, respiratory and health problems, and that is true for the swine flu.

There's been limited testing of

the swine flu vaccine, she goes on to say. Swine flu vaccines have been tested on only a few thousand healthy Americans for a few weeks, and "healthy," I use that term because we know the state of the health of many Americans in this country, and we have probably the highest rate of chronic illnesses throughout the industrialized world. There is little or no information about how safe the vaccines are for pregnant women and chronically ill or disabled children, because only a handful was part of the testing, and nobody will know how safe the vaccine really is until it is given to millions of Americans.

She also goes on to say that swine flu vaccine is not just being given to children and adults in clinics and doctor's

offices, as we heard earlier today in testimony, but we also give it in non-medical settings, like pharmacies, stores, schools, and even drive-by kiosks.

Getting vaccinated in a nonmedical setting can be very risky. Driving a car immediately after getting vaccinated when you can suffer an unexpected

shock, collapse, reaction, can also be deadly when not given in a medical setting of someone who might be able to see those symptoms.

In addition, as John covered and Lou, there's no compensation for swine flu victims. There's no actual compensation for the people who are administering these vaccines under the Emergency Prep Act.

Last, I want to state, that the government, and this is Barbara Lowe, and I agree with this plan, that's why I'm reading this today, government has spent billions on H1N1, the vaccine program. Swine flu shots are free for most Americans because the government has given one billion dollars to

pharmaceutical companies to create the new swine flu vaccines, and has given another five billion dollars to state and federal health agencies to promote and deliver influenza vaccines to people.

Clearly, this is a great deal of money. The push to get vaccinated is like nothing we have ever seen before. And I also want to state, Lou had mentioned about the Hepatitis B shot.

I am a mother of an autistic

child and, you know, when I read that there's an H1N1 pandemic, I have to say, with the new information nationally reported, there's one in 58 boys now, one in 91 children now are reported with autism. That's an epidemic. That should cause for emergency action by all states and nationally.

I want to summarize by saying, in summary, I believe the H1N1 and any vaccination for that matter should not be mandated. Informed consent should be upheld and choice of what goes into our bodies and

into our children's bodies should prevail.

Thank you for this opportunity to speak.

MS. REHMAN: Good afternoon. My name is Sabeeha Rehman. I am the president of the National Autism Association's New York Metro Chapter.

First and foremost, I am a grandmother of an eight year old boy with autism. Omar was three and I was overseas, when my daughter-in-law sent me an e-mail telling me that Omar had been diagnosed with autism.

In that instant, our lives changed. We were working overseas. I am a healthcare executive. My husband say physician. We dropped everything and we made our way back to the states. I gave up my career of 25 years as a hospital administrator and decided to devote my life to my grandchild and to the world of autism.

I cofounded the New York Metro chapter of the National Autism Association, and I now devote my time between running the

chapter as its president, and being there for my son, my daughter-in-law, and Omar. Omar had been doing fine. He was typical, growing beautifully, playing, laughing, hugging, being naughty, like any child. And then, something happened when he turned three. Something snapped. Like the turning off of a switch. He stopped making eye contact, he stopped playing, he stopped talking, and he retreated into a world of isolation.

We couldn't reach him, we couldn't touch him, we couldn't even make him look at us. What happened? Something had to have triggered this. What was it? We back peddled. And we started unraveling

the puzzle. I have since then talked to countless mothers who have had an identical experience as Omar's. I have listened to their stories and all roads lead to one trigger. You know where I'm headed.

In my capacity as president of the National Autism Association's New York Metro Chapter, I come before you to bring to

you the voices of the families who have a child like Omar in their family, the voices of teachers who are educating children like Omar, and the voices of the therapists who are trying to heal children like Omar.

The New York Metro Chapter is not opposed to vaccines. We are advocates of safe vaccines. Vaccines that are toxin free, vaccines that are administered with appropriate intervals. We are opposed to the one-size-fits-all vaccine for children and we advocate the right of choice. The right for parents to opt-out on the basis of philosophical and religious grounds.

I am here today to appeal to you on the ground of safety, safe vaccines. Our first safety concern is the toxins in vaccines. It is an established fact and

we've all talked about this throughout the day that mercury is a powerful toxin. Yet it has been used in vaccines and our children have been injected with this toxin over and over again. We're it has now been removed from most vaccines, it is still

being used in the flu vaccine and, yes, it is indeed being used in the H1N1 vaccine.

Here are the facts. The Sanofi-Pasteur vaccine, it's multidose vial contains 25 micrograms of mercury per dose. Negligible in the single dose, it has point one eight .18 milligrams of monosodium glutamate per dose.

The CSL vaccine, the multidose vial, has 24.5 micrograms of mercury per dose, negligible in single dose prefilled syringe. Novartis vaccine, the multidose has 25 micrograms of mercury per dose, and in the Novartis vaccine, even in the single dose vaccine, has mercury up to one microgram per dose. This is according to the CDC and is it in the package inserts. The presence of mercury in the multidose vials renders these vaccines unsafe for human consumption.

So why don't families opt for the

single dose vial? Because first, they are not aware that they have this choice. Second, single dose vial vaccines are not

available in large supplies because they cost more.

Do they know to ask for a single dose? And if they do, what happens when they are told by their doctor that he or she only has the multidose vials, and the child better get one or they better get one or risk getting the flu. Families are going to do what their doctors tell them to do.

I urge you to insist that only single dose vials are be made available in the State of New York. Let those families who opt for the H1N1 vaccine be given single dose mercury free vaccines, and then, too, exclude vaccines of those manufacturers that have mercury in the single dose vials, keep them safe.

The second safety concern is the composition of the nasal spray vaccine or flu mist. The nasal spray contains an attenuated live virus, a virus that has been weakened, unlike the injectable vaccine which contains a dead virus.

There is anecdotal evidence that

the nasal spray with the live virus has had devastating effects in some children. It's contraindications, as per the vaccine's package insert, includes eggs, gelatin, acronine, among others.

In other words, if you have a hypersensitivity to these, you are likely to have a bad reaction. Children under five years of age and wheezing can also have a bad reaction, and some children have developed, as we have discussed previously, the Guillian-Barre Syndrome within six weeks.

But picture this, a child is given the spray. It appears as if he did not sniff it well. He's given another spray and asked to sniff again, and now you have given him double the dose.

Picture this, a child is given the spray. He rubs his leaky nose with has his hands, his hand are infected with the live virus. Next he is touching his friends with his infected hands and spreading the virus.

The third safety concern is reliability and validity of safety testing. Normally it takes years to conduct safety testing of drugs. The clinical trials on adults for the H1N1 vaccine started in August of 2009. For children on 19 August, for pregnant women, this started in September. And the trials of vaccines with adjuvants started in mid September.

To date, 4,500 individuals including children have been tested. Are we ready to roll this out? We are making these vaccines mandatory for pregnant women when their safety testing started only last month? Is it unreasonable to question the adequacy of safety testing? Can you allay my anxiety about this?

Which leads me to the fourth safety concern, which is vaccinating pregnant women. The package insert on all three injectable vaccines, Sanofi, Novartis and CSL, and the nasal spray vaccine, clearly state that these have not been tested for their impact on the fetus.

I have just shared these with Assemblyman Lancman and you have it in your package. They all warn of the unknown risks to the unborn. We normally restrict dispensing drugs to pregnant women due to risks to the fetus. Should we be giving the multidose vial vaccine with 25 micrograms of mercury, a neurotoxin, when the tiny brain of the fetus is developing inside her? The drug companies have stated that they have not tested the effects of H1N1 vaccines on the fetus, and yet we are urging pregnant women to get vaccinated. If we don't know what the effect this has on the fetus, should we be vaccinating pregnant women?

And if a pregnant women, or anyone for that matter, a parent or healthcare worker has concerns about vaccine safety, should they be forced to get the vaccine? As a healthcare executive and a hospital administrator, I lived and breathed informed consent.

Under the guidelines of informed consent, the healthcare provider must

explain to the patient the risks, the benefits, and the alternatives, and then let

the patient or guardian decide. That is what constitutes informed consent. Informing and educating the patient not just about the benefits, but the risks and the alternatives. Are we doing that? Do we plan to do that, inform the patient, stress the alternatives, hand washing?

And what happens if there are adverse events? A patient gets the vaccine and has an adverse consequence. Should we be aware of the scope of these adverse events? Of course we should. Dr. Birkhead mentioned the Nationwide Registry for Adverse Reporting System. I would take it one step further and recommend that a hotline be established for patients to report adverse occurrences and this should be linked to the Statewide Registry. It will enable you to track and monitor self-reported cases. I urge you to do that.

In closing, my daughter-in-law just gave birth to a beautiful baby girl,

Sophia. I'm relieved that she did not have to be inoculated during pregnancy.

I am grateful that my son and my daughter-in-law, both of who are physicians,

opted out of the Hepatitis B vaccine at birth. I'm going to watch that baby like a hawk, but I cannot do it alone. I, and the families I represent, need you by our side. Make our vaccines safe, please. Thank you.

CHAIRMAN GOTTFRIED: Thank you. First I want to say, I very much appreciate all of you, your determination, and your courage as parents to both get involved and to come to an event like this hearing and testify. I can easily understand that that is not an easy thing to do.

I have a couple of questions. One, I guess I might direct it to Mr. Conte, but not necessarily.

You referred to the Cochrane Collaborative document about effectiveness which I assure you I will read. I'm very familiar with the Cochrane Collaborative and the quality of their systematic reviews.

Do you know whether Cochrane has done a systematic review on the safety of vaccines or of flu vaccines in particular?

MR. CONTE: The review that I cited, which is referred to as Ten Reviews of Research, is a review of flu vaccines excluding the H1N1. The comments that I

gave from Mr. Jefferson on the H1N1 are his conclusions, again, based on that interview with the Italian correspondent that I mentioned, but there is a very good, very thorough review of flu vaccination and, incidentally, other helpful medical interventions with flus, I believe Tamiflu is also reviewed at length, I didn't get a chance to read that as thoroughly as the other ones, but it is very thorough. And, again, it cites research going back to the earliest flu vaccines.

CHAIRMAN GOTTFRIED: Well, again, the review you cited focuses at least from the way you described it and from the headline heading on it on the effectiveness.

Does it also relate -- is there a

Cochrane study or does that one focus on the safety of either vaccines in general or flu vaccines?

MR. CONTE: The report doesn't specifically deal with safety issues, per se. It really deals with efficacy, and tries to ascertain whether, you know, hospital admission rates go up or down.

CHAIRMAN GOTTFRIED: No, I

understand that.

MR. CONTE: And those sorts of issues. So it deals with more whether there's a therapeutic impact from the vaccination. Vaccine safety records are notoriously poor. The VAERS that I mentioned to you, the Vaccine Adverse Event Reporting System is a passive vaccine adverse event reporting system. Most people do not know about it. It is it not posted in most pediatricians offices in our state. I have checked in Westchester where I live. I've never seen it posted in terms of what number one calls.

So it captures, we think, perhaps

two percent of all vaccine adverse events. Quite frankly, there is no publicized well known place for people to call. Most of the times they do what I did, and, that is, I called my pediatrician.

CHAIRMAN GOTTFRIED: On the question of the testing or not of this year's -- of what we're calling the H1N1 vaccine, this year, as every year for the last 30 or so years, the government licenses a flu vaccine for one and sometimes several strains of flu virus that have newly

appeared that year.

The government's view of that is that the only thing different about those vaccines from one year to the next is the particular strain or strains of virus that are killed and chopped up and put in the vaccine. Everything else about those vaccines is the same from one year to the next, and that aspect of each of those vaccines has been extensively tested and does not need to be retested every year.

This year, there are four strains

of flu that have been -- for which vaccines have been licensed. Three of them were identified early enough to be bundled into what we have been calling the seasonal vaccine. One of them happens to be an H1N1 virus.

The fourth one, as I understand it, did not emerge and get identified early enough to be packaged in with the seasonal vaccine. Other than that difference, is there anything about what we're calling the H1N1 vaccine that is -- that would lead one to argue that it needs to be tested in some way different from the three other new

strains that are in the so called seasonal vaccine?

MR. CONTE: I would suggest looking at this a little bit differently. I think it's a very good question because you're asking, "Why is this different than any other flu vaccine?" The first thing is, from everything I've been able to glean from the reporting on the previous swine flu vaccine, that vaccine did produce some very

bad side-effects. I believe it in the neighborhood of 25 plus deaths and several hundred cases of Guillian-Barre Syndrome.

So flu vaccine may be a little bit different. We don't exactly know how it's a little bit different.

But there are two other issues that go to vaccines and vaccine safety. The first is that this is a technology that it was evolved essentially about 80 years ago, and despite what people would tell you, has not changed that much, which is why we're still using the same mercury, thiomersal preservatives, same aluminum adjuvants that we've been using for years. Adjuvants are a significant problem. They activate the immune system in a very dramatic way, but a

crucial difference from 80 years ago, is that there were not four or three vaccines as there were then. Now there is 36. And the process of repeatedly activating the human immune system in this fashion is not studied.

Vaccine components, some are

studied in interesting ways, I would add. One recent study from Italy showed a comparison between a group of people that got some mercury, and another group of people that got a little bit more mercury. It was so that is a way to tell what -- when you remove mercury, this is what you see, we don't see any effect. But that's not really what the research did. It was two groups that both got different levels of mercury. It was not no mercury.

And the problem here is, that we don't have a study of outcomes, health outcomes between vaccinated and unvaccinated populations. There are populations in the United States today already available to us. The Amish and other populations that do not vaccinate their children. It is completely, I think, ethical to investigate the health

outcomes of that population, and study the population of children who are vaccinated in accordance with, say, the New York State schedule which is roughly 36 vaccines. Recently a Federal Advisory Commission, the

interagency commission for -- basically the Steering Committee, the IAACC, I'm blanking on the exact name of it, but the commission was to steer funding from the Combatting Autism Act. There was a small portion of that money to be focused on the study of health outcomes of vaccinated children and health outcomes of non-vaccinated children. The money was not authorized. At first it was voted through, and then an emergency meeting was called by the leader of that committee, Dr. Thomas Insell, who then pulled the funding for that study.

The reason he pulled the funding for that study is he stated, quite honestly, that the Secretary of Health in Human Services is being sued in the vaccine court and they did not want to go there. He was afraid of the optics, as he phrased it.

That's a study that we need to have done because we keep thinking about individual vaccines. The problem may be

over vaccination. It may be that we took something that was good and did work in a

selective manner, but have simply run amuck with it.

CHAIRMAN GOTTFRIED: Okay. But your comments would seem to apply to the first, second, and third strains of flu vaccine this year, equally as to the fourth strain, yes?

MR. GILMORE: Can I attempt to answer your question, Mr. Gottfried?

CHAIRMAN GOTTFRIED: Okay.

MR. GILMORE: My answer is, I can't give you an answer. Myself and other people who I work with have followed development of the H1N1 very very closely. The formulation of it was constantly changing. The three that are licensed right now, or the four that are licensed right now, including the flu mist, I haven't been able to find out exactly what's in it. Perhaps other people have.

Now, your question is somewhat theoretical. If you had an identical vaccine, the only thing being different is that it had the H1N1 strain instead of some

of the other strains, would it require sort of an intensive multi-year analysis? Probably not.

However, the change in a particular antigen is important. And, you know, particularly given the brouhaha about what this vaccine was supposed to be, I thought it would have really sort of deserved a higher level of scrutiny before it was marketed.

So I guess my answer is, I can't really answer you. I would be happy to get back to you, but we really have to get some accurate information of what's in the vaccines. Sometimes that information is quite difficult to get.

I'll give you an example of why. We were involved in the process of changing the formulation of flu shot to get mercury out. That was ultimately reasonably successful. What we found out later, and it took quite a long time to find out, is that once mercury was removed from certain vaccines, the quantity of aluminum used as

an adjuvant in certain vaccines was quadrupled. And that quadrupling of the aluminum content, and aluminum is highly toxic, particularly to the neurological system, that hasn't been tested, and it's also not really known until significant periods of time follow after the changes are made.

So changes are made to the formulations of vaccines after they're licensed and those changes are not subjected to really any kind of meaningful analysis.

MS. REHMAN: And if I may add, I think the question, which is a good one, I see it at the much broader level. I'm not here to compare the seasonal flu vaccine with the H1N1 vaccine, but if a particular vaccine, and in this case, the H1N1 vaccine, if the package insert says clinical trials are being conducted to assess the immunogenicity and safety of the vaccine in healthy children and adults, it concerns me.

When the package insert says, the safety profile of the vaccine in pregnant

women is unknown, it concerns me. When the package insert says that it has 25 micrograms of mercury, it concerns me.

CHAIRMAN GOTTFRIED: But that concern I assume would apply to the vaccine for strains one, two, and three, which also contain 25 micrograms. Okay. I just wanted to clarify to what extent the concerns are focused specifically on strain number four and to what extent the concerns are focused on all flu vaccines that are similarly constituted. Okay. That's the extent of my questions. Okay. Thank you.

Is Medimmune here? I guess not. We will move on to Dr. Michael Schachter.

DR. SCHACHTER: I'm here.

CHAIRMAN GOTTFRIED: You're on.

(The witness was sworn.)

CHAIRMAN GOTTFRIED: I guess in the interest of full disclosure, you are my chief of staff's pediatrician, and that seems to have worked out well.

DR. SCHACHTER: I'm not a pediatrician.

CHAIRMAN GOTTFRIED: Well, doctor.

DR. SCHACHTER: Okay. My name is

Michael Schachter, I'm a physician in New York State with a background in integrative medicine that I have practiced for more than 35 years.

Thanks for allowing me to present my views today. My written testimony has more information. I shortened it to try to stay within the ten minutes. So I handed in ten copies of two of these. The one I am presenting, reading from, is the first one, and the second is a little more information.

Over the years -- and I have to say that I think the presentation preceded me was incredible and kind of too bad that some of the other people could not hear it earlier.

Anyway, over the years, I have become increasingly concerned about adverse effects of vaccines upon all aspects of health. The mandating of vaccines to children and now adults amplifies my

concerns.

In my written testimony, I outline what I believe to be the primary economic and political forces that have lead to mandating vaccines. I identify four

interrelated factors, namely, pharmaceutical companies, the healthcare industry, government, and the media.

Within this framework, there are considerable conflicts of interest and I outline how I believe money, rather than the welfare of the public is the primary concern.

Over the past few decades, there has been a tremendous increase in the diagnosis of autism, and you just heard eloquently about this. Just within the last few weeks, and this was also mentioned, the federal government issued its latest figures on the rate of autism in children in the USA as of 2004. The figures mentioned were even worse than the ones that I have, one in 100 children, and one in 62 boys.

This compares with a rate of one

in 10,000 in the early 1980s before the tremendous increase in mandated vaccines for children. Recently, controversy has raised over the possible role of vaccines in causing autism.

Government agencies and most healthcare officials have been quick to issue statements indicating that they don't

know what has caused the increase in autism, but they they're sure that it has nothing to do with the increase in the vaccine schedule.

Despite this position, federally funded courts have found a relationship between vaccine administration and brain damage in certain susceptible children. Again, you just heard some personal descriptions of this. This brain damage is given other names, but much of it has the characteristics of autism.

In spite of this, the most basic studies that compare the rate of autism in vaccinated and non-vaccinated children have never been done by any federal or state

agency. And that was just stated before, too. How is this possible unless decisions of people in power are being heavily influenced by conflicts of interest?

Nevertheless, this was also mentioned, some unofficial information is available to us. The Amish community in Pennsylvania do not vaccinate their children, and there is virtually no evidence of autism in any child born to that

community.

Mayer Eisenstein, M.D., a physician and attorney, who heads an HMO group of about 28,000 people in the Chicago area, does not advocate vaccinations for the children in that group, and he claims that in his HMO, he has no records of children with autism who have not been vaccinated.

He also says that the incidence of asthma among these unvaccinated children is zero, as compared to the incidence of about 13 percent on the general population. My written testimony indicates his website and several other websites that I'm kind of

passing over and talking about.

On the other side of the coin, David Kirby, writing in the Huffington Post, discussed in detail autism in Somali immigrant children in Minnesota. Although parents of these children had never heard of or seen any autistic children in Somalia, after they immigrated to Minnesota, an astounding one in 28 of these Somali children have been diagnosed with autism. Although most of the parents interviewed strongly suspected that the intensive vaccine program received by these children

had something to do with the autism, Minnesota health officials were sure that this was not the case, although they had no other explanation.

Conventional medicine's position that there is no relationship between vaccines and autism is allegedly based on 14 studies. In my written version, I discuss a website that contains the actual 14 studies and critiques of them.

In my opinion, they fail to prove

that there is no relationship between receiving vaccines and autism. I also discuss several other websites that contain information about the relationship of vaccines to autism and other conditions.

So, who are we to believe? Should we believe the government agencies, healthcare practitioners, and media with their conflicts of interest? Or should we believe the thousands of parents with video home movies, which clearly show a perfectly normal and healthy child who develops autism after receiving one or more vaccines? Again, you just heard three testimonies concerning this.

In the early 1980s, as many as 10 vaccines were given, and incidence of autism was around one in 10,000. At present, a child may get -- and, again, you heard numbers 36, but the figures I have as many as 81 vaccines, if you count each organism as a separate vaccine by six years of age.

Frequently, five or six vaccines are given at one time. Most of these

vaccines are mandated for children. Do all children suffer from damage from the current vaccine schedule? We really don't know. But, damage or disease will relate to genetic propensities and other environmental exposures.

Damage from vaccines is undoubtedly cumulative and common sense tell us that the more vaccines given over a short period of time, the more likely there will be damage.

There has been a tremendous increase in certain childhood diseases since the increase in vaccines. These include autism, asthma, attention deficit disorder, with or without hyperactivity, allergies, and cancer. Could this drastically increased vaccine schedule be contributing,

or even be the main factor in the development of all of these chronic diseases in children?

As I review much of the peer reviewed medical literature which includes information about all of the dangerous

components of vaccines, and you heard the details to that just now, I am convinced that there is a good chance that this is the case.

Many scientific studies suggest that damaging effects from the interaction of the toxic substances in vaccines is not only additive, but synergistic. And John Gilmore mentioned that in terms of mercury and aluminum, that the effect is not just the addition of the toxic effects, it's actually a multiplication of the toxic affects. Little attention has been paid to this issue by the officials who mandate the vaccine schedules.

Furthermore, there is little informed consent because parents are not informed about the potentially toxic and dangerous effects of the vaccines in susceptible children, such as those who have

a problem detoxifying and getting rid of mercury, and who have, for example, mitochondrial dysfunction. The point is, of course, not every child is going to develop

autism or brain damage from these vaccines, but the children with certain kinds of genetic propensities, such as difficulty detoxifying, getting rid of mercury, aluminum, and other toxic effects, those children who hang on to them and it settles in their nervous system, those are the ones that you'll see the damaging effects.

This mitochondrial dysfunction is much more common than vaccine officials are willing to admit.

Informed consent implies choice and parents are given little choice since they are not told -- they are told that they may not enroll their children in school if they are not vaccinated.

So regarding the swine flu vaccine specifically. There is literal evidence, as you just heard, that the current swine flu is any more dangerous than the seasonal flu, and little evidence that the swine flu vaccine will actually be effective in significantly reducing the

incidence of this relatively benign disease.

On the other hand, most of the injectable forms of swine flu, the vaccine will contain mercury containing preservative thimerosal. Mercury is one of the most neurotoxic substances known to man.

When we talk about toxicity of lead, we're talking about a hundred, two hundred parts per million. When you're talking about toxicity of mercury, you're talking about one part per billion. So if you have a swimming pool, and you drop a few specs of salt in it, that's enough to have a toxic effect. That's how toxic the mercury is.

The amount in the vaccine is in the toxic range. Furthermore, there is considerable evidence that the combination of mercury in aluminum, also present in the swine flu vaccine, has a more harmful effect than the sum of the two toxicities, which I mentioned which the other members of the group before me mentioned.

In addition, swine flu vaccines will contain an adjuvant squalene. I

learned today that maybe it won't contain squalene. I'll just mention what it actually can do. It's supposed to make the vaccines work better by enhancing the immune response. But when squalene is given by injection -- now squalene is a substance that we make in our own body. We can actually -- Vitamin D is -- the precursor of Vitamin D in our body is made from squalene.

ASSEMBLYMAN LANCMAN: If I may. It's just my understanding from looking at the CDC's website that squalene is not in the H1N1.

DR. SCHACHTER: Okay. There's been a lot of stuff back and forth as to whether it's going to be, so maybe it won't be and maybe it isn't at this point.

But anyway, squalene, it may combine with other foreign substances in the vaccine to stimulate an autoimmune response, so that the body makes antibodies against the squalene and other body components. Of considerable interest, is that squalene is believed by some important scientists to

have contributed to the Gulf War Syndrome as it was a component of some of the vaccines like the Anthrax vaccine that the troops were mandated to receive.

Also of considerable interest, is that the swine flu vaccine was tested without the addition of squalene but, supposedly, what I had heard, and, again, this may be incorrect at this point, which may be a fluid situation, but the actual vaccines will contain it.

This vaccine has not been tested adequately for safety or effectiveness and lawsuits are being filed in New York State and in federal court to prevent mandating its use.

I also might mention, just on the first testimony today, Dr. Birkhead, he mentioned as proof that flu vaccines are safe, he said, well, we give hundred million shots a year and, you see, no problem. That's not proof of safety. I mean, look at the amount of chronic disease, this was mentioned, look at the amount of chronic

disease that we have in this country, and

many of these effects may occur weeks, months later these autoimmune responses. How does one know? How can you prove that the vaccines have nothing to do with it. There's a lot of peripheral laboratory data and animal data to indicate that it may actually have an effect like that.

So what about forcing healthcare workers to take the swine flu and/or seasonal flu vaccine which contain thimerosal? I know of a nurse and this is a person that I know personally and works in a hospital and is responsible for sending her children to college as her has husband has lost his job in this economic tumultuous time. She has a history of breast cancer and has made major changes in her lifestyle, including dietary changes, exercise, use of protective nutritional supplements. She's very health conscious and even avoids any wine as she is aware that even wine glass of wine daily has been correlated with an increased risk of breast cancer. She avoids

all mercury like the plague and is very concerned about take a mercury-containing vaccine as she believe it is may increase her risk of breast cancer recurrence.

So what is she to do? She should she take the vaccine against her belief that it is safe for her? Or should she be fired from her job for refusing to take it and thus leave her family unsupported? Is this fair? Is this right?

As can you deduce from this testimony, I believe that the entire vaccine program should be reevaluated for safety and effectiveness. Mandatory vaccination should be eliminated and people should be given the choice as to whether to vaccinate or not based on a proper informed consent. Studies should be done comparing various health parameters of the vaccinated and non-vaccinated groups.

Alternative vaccine schedules should be an option with a reduction in the number of vaccines and the opportunity of giving only one vaccine at a time, spread

over time.

I suspect that implementing a policy such as this would vastly improve the health of the pediatric population in New York, and also significantly reduce healthcare costs.

Certainly, no one should be forced to get the swine flu or seasonal flu vaccine which contains toxic substances and have not been adequately tested.

Finally, on a personal note, for the first 20 years of my professional life, I did not believe that vaccines could be harmful, and more or less believed everything that I was taught about vaccine safety. Only after studying the scientific literature intensely about vaccines and applying common sense to my own observations, did my view drastically change.

I believe most doctors, scientists, and healthcare providers want the best for the public. So what holds them back from seeing what, to me, seems

absolutely obvious at this point?

In addition to the financial considerations that I have discussed in the longer paper, I have outlined, I believe that the notion that our public health policy and our pediatricians have contributed to the irreversible damage to a generation is so horrendous that it is impossible for them to look at the truth.

Thank you.

CHAIRMAN GOTTFRIED: Thank you. Just in terms of a context of the regulation, one thing that I would recommend to the nurse you were talking about is that her physician or nurse practitioner provide a note saying that in his or her judgment, the vaccine is contraindicated for her or, in the alternative, remember to give hear a single dose, an injection from a single-dose vial which would not contain thimerosal. Either of which would be an option under the regulation.

DR. SCHACHTER: Well, I'm not so sure that the first is really an option

because I just received about six pages from the health department and it seems to me that the only thing that they're accepting is a possible opt-out for a medical reason is allergy to eggs. That's all I could see.

I mean, I don't know that putting down that I think that mercury and taking vaccines may impair her immune system to the point that she may actually get an increase of breast cancer. That's not a popular medical opinion these days.

In doing such a thing, if a doctor were to do this, it raises the issue earlier that was raised by John Gilmore that doctors feel endangered themselves if they start doing something like that, that they get investigated, the next thing you know, they're spending $100,000 in legal fees trying to depend defend themselves before OPMC and may wind up losing their license.

CHAIRMAN GOTTFRIED: Well, in terms of the language of the regulation, it is very clear that the Health Department's opinion of what is or is not a medical

contraindication does not factor into this regulation.

The regulation is very clear that if the patient's physician or nurse practitioner says it is medically contraindicated for that patient, that is the definition under the reg of medical contraindication.

DR. SCHACHTER: And no reason needs to be given? Just say that it's contraindicated for the health of that patient and that's sufficient?

CHAIRMAN GOTTFRIED: I don't think Deputy Commissioner Birkhead likes

that, but that is what the regulation says.

DR. SCHACHTER: Well, that's good to know because I didn't know that. Thank you. I will certainly pass that on to her.

CHAIRMAN GOTTFRIED: Thank you. Any other questions?

(No verbal response.)

Our next witness is Gary Null.

(The witness was sworn.)

DR. NULL: Thank you. I'm going

to try to bring four separate pieces of the puzzle together. Some of it may include some of what you've already heard, but I know for a fact that much of it is different.

There is an old Jewish saying, a half truth is a full lie. I being my discussion by asking two basic questions. Are vaccines safe? If so, what is the proof? Are vaccines effective? If so, what is the proof?

I am not talking about all vaccines, though this applies to all vaccines specifically on what we're dealing with.

I have reviewed the scientific

literature extensively. I've spent the last seven and a half years with thousands of hours of research on the subject of autism, and what connections they may have to environmental factors including vaccine, not just the thimerosal in vaccines but the other ingredients as well.

I produced an award-winning

document called Autism Made in the USA. I produced a separate document called Vaccine Nation, representing all sides, all 50 primary sponsors in the United States of vaccines in general is in there and it has his say.

I then did something that I thought had been done, and I was surprised when I realized, it had not. When I began to review what amounted to thousands of peer review literature studies on vaccines, I found that I could find no convincing evidence that any vaccine at all had long term double blind placebo controlled study trials, and even when they said -- when the evidence I did examine that the CDC and the FDA and the organizations were using as, of course, there are studies, and they showed the studies. They would say, well, this is

a study, and then I would find that, well, you left out the virus part of the vaccine, but you included all the other ingredients, including thimerosal and mercury and formaldehyde, et cetera. Well, that's not a

placebo. And, in good science, you don't use that as a placebo.

I also saw that virtually all the studies that were supporting the vaccine were done by the vaccine manufacturers. Since the FDA does not do independent studies on the creation, safety, and efficacy of vaccines, but rather relies upon the information from the vaccine manufacturers, and there's a very close relationship, I then took a very careful look at this relationship and found that more than 50 percent of the people sitting on the FDA and CDC's vaccine advisory program were from vaccine manufacturers. I felt this was a gross conflict of interest. The rationale was given that there are not enough experts who are independent to sit on these committees. And I thought, that's absurd. There are more than three million outstanding scientists in the United States,

don't tell me you can't find 15 who have no industry affiliation to sit on a vaccine scheduling committee.

I then took a careful look and here's what I found, and this is where you have to bring the pieces together or you lose site. We're too close, too narrow on this issue.

First, when a child is given a vaccine, adult is given a vaccine, a senior citizen is given a vaccine, rarely, if ever, has anyone done any study that I can find and I'm open to the fact I may not have found one that was done, but I looked at thousands where they looked at combinations of vaccine used in a given individual to see what short long term impact it might have had.

Now, the panel before said that only two percent of vaccine adverse reactions are reported. The highest number I could find was the FDA's 10 percent. When you consider $1.3 billion has been given out in vaccine damage, and you consider that the criteria for receiving that award is based upon getting the proof that your vaccine injury occurred in a very narrow frame of

time, and then you look at the epidemiological evidence, you talk with immunologists, you talk with people and in every specialty of medicine, they will tell you, many people will have a delayed reaction to a vaccine. It might be a month, six months, a year, even two years.

For 18 years, sir, I have been trying to help the Gulf War veterans in the United States do something that I'm appalled to say that our federal agencies have failed to do, including the Bush senior, Clinton and Bush Junior administrations. Acknowledge that 400,000 GIs who are sick with Gulf War Syndrome actually have something other than post traumatic stress disorder.

I have done three award-winning documentaries on their plight. I have interviewed over a thousand of them. I have interviewed people who have massive body lesions who have rare and exotic diseases who have brain neurological disorders having nothing to do with post traumatic, didn't

even go to the Gulf theatre. They got the vaccines. They the experimental Anthrax vaccine, the experimental botulism vaccine that the FDA, similar to what is -- doing with swine flu, gave a pass, an exemption on long-term studies.

Those Americans, those brave, courageous Americans, over 33,000 are reported dead. Their statistics appear nowhere. Only by those who were Gulf War veterans putting together their own figures. They've gone to Washington. I've gone to Washington and interviewed the people in the presence of the Gulf War vet, a man who got out of bed in the morning, had to crawl to get to his daughter because his legs were swollen the size of a football.

A woman who had no illnesses, 22 years old, was in the Gulf, but got the vaccines, and now couldn't walk. In bed, 16, 18 hours a day. The government has refused to acknowledge the Gulf War Syndrome is legitimate to this day.

Now I've head the hearings and I

saw all of those white coat phenomena. The scientists in positions that we bow down to, marching in and giving testimony. I have every word they said at every committee meeting. Rockefeller Committee, all of them, and they all were in gross denial. Whose interest were they serving? Certainly not the sick Gulf vets. And you would see the Gulf vets determined to get their story out. No one listening.

No one has looked at the facts. Yet, there are 44 separate studies, 44 to date that show that Gulf War Syndrome is real and that is due to what they were exposed to. These are real diseases for a decade, and, more, they said there's no diseases.

Now I'm wanting to ask, you're willing to inject pregnant women in this state or fire them if they don't take the vaccine, are you or any member here, is the Governor, is anyone in the state going to be held personally legally responsible if that developing fetus gets that mercury into

their brain and ends up with a learning disability, with autism, with any one of the

autism spectrum disorders, or ends up with some form of intellectual deficit? We have an epidemic.

I did another award-winning document called the Drugging of Our Children. It's appalling to know when you were going to school, when I was going to school, no kid got drugged.

Today, 10 million American children don't go to school before they get a Class 2 drug, in the same class as Cocaine. Do we actually have a new epidemic that didn't happen to any generation in American history anywhere else in the world, but suddenly happened in the last 25 years to the newest generation, they have a brain chemical imbalance? No.

And, yet, the so called experts, the very experts that you would rely upon would say, well, there's must be something wrong, that's why we're giving them the drugs. The drugs must work. And I say, no.

The number one cause of death in the United States in 10 to 14 year old boys is suicide. How many kids committed suicide when you were going to school, sir? None when I went to school, and I went to the largest high

school in my state, 5,500 students. Partridge Bridge High School.

So what do we have, a whole new generation of people where autism is suddenly showing its head but never before. If autism was historically there, then everyone in their 50s, 60s, and 70s would start representing, at least percentage wise, population autism in adults. We don't see it. It doesn't exist.

And, yet, we refuse to acknowledge that what they're getting early in life could be contributed to it. So I'm saying, I'm not willing to sit by quietly and allow women who have been used and abused by the medical authorities, the very same medical doctors who will sit here with great certainty and enormous hubris and contempt for women say, your body is our

concern, you're developing fetus is in our best interest to make sure it's born healthy, and, yet, give them mercury.

You ask that same doctor, would you give that woman lead? Would you give anyone in this room lead? If you did you would go to jail. So you're going to give

something more toxic than lead to every one of these pregnant women? Sir, I am appalled and I'm offended in the extreme, and I will not contain my concern because these same women that were so called interested in -- for the last 35 years, I've been one of the leading people advocating against synthetic hormone replacement therapy. We know now it causes breast cancer, ovarian cancer, heart attacks, dementia and stroke. 10 percent minimum, 13 percent more likely. You're talking about 10 million women. That's 1.3 million women we're allowing to be sacrificed on the alter of ignorance or greed or hubris.

My mother died of a heart attack in the middle of the night and she was

taking synthetic hormone replacement therapy.

Now another part of this scenario is the number one cause of death in the United States is American medicine. I did a report that has not been refuted with five other MD board certifiers and Ph.Ds called Death By Medicine.

I was intrigued when the American Medical Association said that the number

three or four cause of death in the United States was isogenesis. What they failed to mention were all the other causes.

So we did the same statistics using their statistics, no one else's, and no editorializing, and we found that more Americans die each year from medical errors than heart attacks or strokes or cancer. More are injured. 723,000. Dr. LaPey from Harvard considered the United States' expert on this said over a million. We were even conservative. And our figures and his figures do not account for anyone who has had an adverse reaction at home. Only in

the institutional settings. So the figure is much higher.

Now you would think that if you have more Americans killed each year preventable deaths, more Americans injured, preventable injuries, then all of American casualties in the first and second world war combined in one year, that there would be a hearing, a committee, some open forum, such as this, which I'm happy you're doing. Nothing. It's the 10,000 pound gorilla in the room.

So if America medicine is incapable, as good as we are, and I respect what works in American medicine, it saves lives, but I'm also very much concerned about the lives it takes and does not acknowledge.

So now I've got a problem with a doctor giving me some certainty, whether it's a doctor in private practice or a doctor at the state board level saying that, trust us. I'm saying, I'm trusting the science, and the science does not show that

you deserve my trust.

Now the World Health Organization I believe is disingenuous and playing half truths. As of May 2009, a pandemic was defined as -- from the World Health Organization, "an influenza pandemic occurs when a new influenza virus appears against which the human population has no immunity resulting in epidemics worldwide with enormous numbers of deaths and illness."

Now, today it reads, "a disease epidemic occurs when there are more cases of that disease than normal. A pandemic is a worldwide epidemic of a disease. An influence of pandemic occur when a new

influence of virus appears against which the human population has no immunity."

Conclusion, by the new definition, the world will always be in a pandemic requiring flu vaccines. This is not what the World Health Organization recently announced.

Now, the efficacy. Dr. Anthony Morris, who should have been here, the

former chief vaccine officer, top authority at the FDA, "the producers of these vaccines know they are worthless but they go on selling them anyway." CDC officials have confessed, "influenza vaccines are the least effective immunizing agents available, especially for the elderly and the children."

So when I was in Albany last week and met with a physician, I asked a simple question. Why are you giving this up first to pregnant women, children, and senior citizens? Well, because it's going to save the senior citizens. I had five peer review studies. The only five peer review studies considered of quality showing efficacy levels for the swine flu vaccine. Zero, two

percent, seven percent, nine percent. That, for the flu vaccine, would be considered completely, statistically, non significant, and, therefore, there is no protection that we can say that the flu vaccine or the swine flu vaccine confers upon senior citizens.

Yet, with just a dismissal of a

thought, it went out the window. Well, not when you're a senior citizen and more likely to have a compromised immune system. We have more illnesses in the United States today than ever before in our history.

We have epidemics of immune-related illness. Arthritis, diabetes, cancers, lupus, fibromyalgia. These are not healthy people, and, yet, in the FDA -- they mentioned earlier, Dr. Tom Jefferson at the Cochrane database, a review of all published and unpublished efficacy evidence, and I looked at all their actual studies. I didn't take his word. They found only one safety study performed with an inactivated flu vaccine conducted back in 1976. "Most studies are of poor methodological quality and the impact of confounders is high."

"Evidence for systemic reviews

show that inactivated vaccines have little or no effect on the effects measured."

"Immunization of young children is not lend support by our findings."

We recorded no convincing evidence that vaccines can reduce death, hospital admissions, serious complications, community transmission of influenza."

"In young children below the age of two, we could find no evidence that the vaccines were different than a placebo, and then last week, the National Institute of Health announced two efficacy and safety trials underway; one for pregnant women, and another for healthy adults with asthma.

Now, look at the analysis. There are no control groups. To me, that inactivates the quality of the study.

In the exclusion criteria for pregnant women. "If a pregnant woman shows a temperature spike of 100 degrees Farenheit or higher in 72 hours from receiving the shot, they are excluded from the study." Hello. Hello. My God, what has happened? Has science gone crazy. The whole idea is that if a pregnant woman has a vaccine and

she has a temperature, you immediately say that is causative action and must be

considered and examined. You're going to exclude her? This is a fixed study. This is absolute scientific fraud, and I will sue these bastards, trust me. I am not a person to be played with on these issues, and I have the resources and the attorneys to do so.

I'm not going to allow another one of these stupid industry studies, no. Now, I can go on. I'm not going to because many of the people have touched, but here's what you didn't know. None of you knew, no one in America knows this, so this is something you should think on, sir, and I'm not holding you responsible for my thoughts or my emotions, so please do not personalize it, all right? You're here. You have to take a lot of stuff today, I'm sorry to be the bearer of my own energy to you. All right?

I decided to do something I'm embarrassed to say no one in the media has done. I wanted to see the efficacy -- excuse me, I wanted to see the character of

the people that we've been supporting. Much like the banks that were too big to fail and the 20 banks that were solvent and gave all that TARP money to.

Well, I looked into their background and I found that they have settled nearly a trillion dollars in lawsuits for every crime you can imagine. Now, if you or I committed the kind of crimes that these individuals committed, we would not be help up as a character of high value.

Then I went to the vaccine manufacturers, the very people we trust. The people we say, if you're giving us a vaccine, we're going to accept that you've done the good science, that you have no ulterior motive except to protect people, and if you make a little profit, fine.

I have all their data from lexus nexus. I hired a group of young attorneys who are researchers and I said, I want every study. We now have, just a sampling, 132,000 lawsuits. Let me repeat this, sir.

132,000 lawsuits that these individuals have paid for fines from price fixing, falsifying scientific data, skewing studies. Knowing in advance that they had unhealthy and toxic drugs and allowing them on the market. Why? Because it was considered the cost of doing business. The cost of doing business ended up causing 43,000 Americans to die from one drug, one drug, Vioxx.

Dr. Graham of the FDA who I interviewed who was a very conscientious person said he went to the FDA, and his own office, and said, we can't allow this drug out. It is dangerous. They kept him quiet. They intimidated him. They threatened him. He's on the record saying that. And Vioxx came out. In four years, it killed 43,000 people, injured 125,000 and, yet, they settled a lawsuit for $4.85 billion and their stock went up. My God. Where else but in America could you kill 43,000 people and get a raise?

Am I the only person who finds this rather odd that these serial criminals,

these absolute criminals are the ones that

we trust with our health, an entire nation put at risk. Now if they had had a clean record, if they had only been shown to do good things for the public, yes, but I've got 132,000 studies -- lawsuits settled. How many do I not have that were settled and no amount was given? Triple that. Over a trillion dollars.

So here we have it. People who have committed crimes. The crimes end up causing death and injury, and we give them a clean pass, a get-out-of-jail, no character assassination, nobody goes to jail, nobody is harmed, your reputations are intact, in fact, we don't care what you do. We don't care how many crimes you commit. We don't care how many Americans you kill or injure. Go ahead and make us our vaccines. They say, well, we need to give them the subsidies. We need to give one billion to one company, two billion to another, four billion to another.

I managed to find their actual

very important part of this. Celebrex, 100 milligrams. You pay $130.27. They pay for the cost of the generic active ingredient the same hundred capsules, 60 cents. Their marked up 21,712 percent mark up. Then you have Claritin, 10 milligram, consumer pays $215.17, their cost 71 cents, 30,306 percent mark up. I'll skip some that are lower in the 8,000, 10,000 percent. Let me go to Norvax, 10 milligrams, $188.29 you pay, they pay 14 pennies. 14 pennies. That's 134,493 percent mark up. Then Prevacid, 30 millions, $344.77, they pay a dollar one. That's 34,136 percent mark up. And let us not -- Prilosec, 20 milligrams, $360.97, they pay 52 cents, 69,417 percent, but I've saved the last two for best here.

Prozac, we've all heard of Prozac, 20 milligrams, $247.47, they pay 11 cents. 11 cents. 224,973 percent.

ASSEMBLYMAN LANCMAN: I'm sorry,

I don't mean to interrupt, but there are many other people who would like to testify.

DR. NULL: And finally Xanax, one milligram of Xanax cost you $136.79, they pay two cents. 569,958 percent mark up.

So what we have is we have some

extreme profit, more than any other industry, more than any other products that I'm aware of, from people who have committed massive crimes against humanity and gotten a clean bill of health for it, who are telling us to believe that their vaccines are safe and effective. They have no double blind placebo control studies, no ruling to allow the most vulnerable amongst us, the children, pregnant and seniors to get this vaccine.

I'm not opposed to any vaccine that can be shown to be safe and effective.

I am opposed to science that is so faulty, and so ridden with inconsistencies and contradictions, that they're now allowing an open debate between those of us who do look at the science and

they who are claiming it. This is not a secret. This is in full view of the public.

I'm concerned that we do not allow people in our society a freedom of choice. Democracy is about freedom of choice. You can believe any religion is the right one, any job you want, any political party, why can't you have the same right of

choice about your body and your health?

I am a healthy American and I do not want to, as a healthy American, a toxic drug in my body. To me, that's a violation of my constitutional rights as well as just decency and ethics.

Thank you very much.

CHAIRMAN GOTTFRIED: Can you point us to, I'm going to I guess repeat the question that I put to Louis Conte and John Gilmore, can you point me to a systematic review of the safety of either the flu vaccine, or --

DR. NULL: I can, sir. I gave the women at the door 10 copies of 100 pages with 207 scientific references, no

editorializing, pure science, a review of the safety and efficacy studies of the swine flu and the flu vaccines only. Nothing else mentioned. And it is complete, only peer review literature was used, and you have a copy of it.

CHAIRMAN GOTTFRIED: Who did the systematic review?

DR. NULL: A group of researchers, myself included. People with backgrounds in molecular biology and

internal medicine and biology.

CHAIRMAN GOTTFRIED: Okay. That that would be your reference then?

DR. NULL: That is the reference, yes, sir. And I might mention, I keep hearing everyone say the expert panel agreed that there was no connection. I heard it earlier in the day between vaccines in autism, but I actually happened to go to the research and I found that that was absolutely not true.

In fact, the members of panel of that vaccine oversight committee, 13 members

of the committee said that there was a connection. They had no vaccine or drug company affiliation. The small percentage said there was not a connection, all had vaccine or drug company affiliations. I'm surprised that that information has not been made available. I also have all the studies on the sicknesses that children have developed when they've taken the flu vaccines and all these are from separate studies. They're all peer review.

CHAIRMAN GOTTFRIED: Okay.

DR. NULL: Thank you very much.

CHAIRMAN GOTTFRIED: Quick question. How many people who have signed up to testify are still here? Okay. A fair number. Then we're going to take a 10-minute break and come right back. And we're not having sandwiches, so it will really be five or 10 minutes.

(A break was taken.)

CHAIRMAN GOTTFRIED: We are going to resume. I'm going to ask that all of the remaining witnesses, if you can keep your

testimony within five minutes, unless you're really making a point that several people have not made already, I think we would all appreciate that, and I'm particularly concerned because we have several staff people who are down here from Albany, and if they don't make the last train out, they're here over night, and considering if they don't have hotel reservations, would be a difficult thing to do.

So I'm going to ask if we can do that, and, certainly feel free to abbreviate your testimony even more by reference to other people's testimony.

Okay. Resuming, our next witness is Heather Walker from the Coalition for

Informed Choice.

(The witness was sworn.)

MS. WALKER: Good evening, thank you for calling this meeting. My name is Heather Walker. As a matriculated student of occupational therapy, on September 11th of 2009, I was informed by my school department chair that I am required to be

inoculated with the seasonal flu vaccine and the H1N1 vaccination in order to remain a student in the college program.

I have severe reservations concerning both vaccinations. As a single mother of a vaccine-injured child, who at age three was developmentally normal, received the flu vaccine and regressed into autism, I will, under no circumstances, consent to this vaccination due to the harm I watched my son endure.

The result of my decision to not take the flu shot means that I will lose my tuition monies and future calling of a career, but, most importantly, my son will lose the knowledge his mother would have gained for occupational training he so desperately needs.

Now, as an administrator for the committee for New York HealthCare Workers for Coalition for Informed Choice, I will now read a statement from the director of this organization. This is a statement by Gary Krasner:

Thank you for holding this hearing. Your commitment to the issue of informed consent is greatly appreciated. Coalition for informed choice is a free to join, nonpartisan, statewide New York only coalition that includes parents, doctors, lawyers, teachers, college students, and organizations.

As its founder and director, I will tell you that we are committed to the idea that parents should be the final arbiters of whether or not their children receive a vaccination.

Parents have intimate knowledge of their children's mental and physical condition.

The views of our members compromise a wide spectrum of thought, from those who accept the general efficacy of vaccination, to whose those who reject it entirely. But all believe, as you do, that

informed consent implies the right to withhold consent.

Mainstream news organizations

have been quoting survey after survey showing that vaccination compliance among doctors and nurses are under 50 percent. On October 7th, health and human services' Secretary Sebelius said she was "really stunned" that only 40 percent of U.S. healthcare workers get seasonal flu vaccines.

But I'm not stunned. For the last 20 years, I've collected news articles of various hospital administrations around the nation attempting to require nurses and other hospital staff to obtain the flu vaccination. Such attempts resulted in rebellions by the unions representing these workers. The only reason union reps would draw the line on this issue was because there was a consensus by its members to refuse the vaccinations.

The morale problem with this appeal when backed by government mandates is that it violates the Nuremberg codes which prescribes government policies that compel

individuals to submit to medical procedures

that pose a risk to their lives. Herd immunity is, therefore, in the very least, a moral corrupt ideology. At most, it's a medical mythm, along with the fact that there has been no prior surveillance of the H1N1 to determine whether or not the current infection rates are the normal background incidence for this relatively mild flu strain.

Because if the rates today are no different than the rates in the past, then there would be no exigency for the current vaccination campaign and mandates.

People do not give up their careers for nothing. Yet, many nurses and hospital staff will do just that rather than to submit to vaccinations. We will be watching to see whether or not the next mandates to befall restaurant workers, teachers, and all manner of service workers will follow suit, because the "herd" is not limited to hospital buildings.

A nurse spends eight hours there. The remainder of her time is spent shopping

for food, traveling on public transportation, and kissing her children good night. In other words, they don't live the life of monks in monasteries. Who will be next required to shoulder the burden of herd immunity?

Thank you.

CHAIRMAN GOTTFRIED: Thank you very much. Next is Barbara Kaplan.

MS. PALMA: I'm reading this for Barbara.

(The witness was sworn.)

MS. PALMA: This is read from Barbara Kaplan's.

My son was fully vaccinated and he is diagnosed on the autistic spectrum. My nephew was vaccinated, and his diagnosed on the autistic spectrum.

His brother is not vaccinated and his neuro-typical. My niece's mom got a thimerosal-laden flu shot while pregnant. My niece is developmentally delayed. My brother-in-law is a nurse. Given what he has seen with regard to his children, niece

and nephew, how could he in good conscience receive any flu shots?

That's Barbara statement, and you're free to answer the question.

CHAIRMAN GOTTFRIED: Are you also going to want to give testimony in your own name?

MS. PALMA: Yes, I will. Would you like me to do that now?

CHAIRMAN GOTTFRIED: Yes.

MS. PALMA: This follows fairly logically, long day, a lot of great things said here. I agree with basically any sentiment that would oppose the mandate, but I wanted to speak to the medical waiver a bit, and the philosophical waiver, and the religious waiver, a topic that I know I have very familiar experience with.

I filed what should have been three legitimate medical waivers to refuse the vaccination Tdap for my 12 year old son. The first one, written a year ago, was rejected with no reason by my school district. I also submitted a titer's test

that contained satisfactory antibody levels to decline the pertussis shot for a boy who

already had the disease. That was rejected.

My second letter, which will be my third medical waiver, awaits a "decision" from my school board as we speak. This letter from my MD stated not simply the shot may harm my son, which the law requires, the letter stated, the shots would harm my son.

My doctor has offered to testify. Assemblywoman Ginnie Fields and Senator Brian Foley, both personally called the superintendent of my school to advocate for me for which I am deeply grateful. Jenny told me, "Rita, they're going to deny you, but you already knew that. I have been trying to strengthen the existing exemption laws, both medical and religious, for several years. Both waivers are frequently rejected regardless of the fact that -- that they fit squarely with the law.

Assembly Member Gottfried, you have a bill currently active that insulates the medical waiver so schools cannot reject

it. This is precisely the same issue that a previous speaker addressed regarding medical waivers for healthcare workers.

You seemed very surprised that

medical waivers, as specific as the statute is, could even be entertained to be rejected. But it goes on all over the place.

Currently, I'm working with a woman who has no fewer than five medical waivers. Two of them permanent, written by three different doctors. They were all rejected by her school district. It is her burden to fight this. Medical waivers being rejected goes on all over New York State. The school districts do not need a reason, and it sounds like the employers receiving medical waivers regarding the healthcare worker mandate, they don't really need a reason either. It's wonderful to have a law in print, but it's quite another thing to compel organizations to actually follow it.

So I would request that the bill that you have active, 880, be revamped to

include the healthcare workers and make it rock solid, make it so the school districts and the employers cannot reject the medical waivers. Make it also so that the doctors writing out these medical waivers can't be harassed, bullied, intimidated, reported, red flagged, and everything else you can

imagine by the Department of Health.

I'd also like to talk about the philosophical exemption that was touched on before. This is my main goal as far as vaccine legislation long term, and I wasn't going to talk about it today, but it did come up, so I would like to touch upon it.

20 other states in the United States representing over half of the U.S. population have a philosophical waiver available to them.

I sat through a hearing last December where a doctor stated that the more -- the easier it is -- something like, the easier it is to opt-out of vaccines, the more people will do it and the more death will follow.

That is such an extraordinary stretch of reality, but better than just hear it from me, I researched to see what the other 20 states are doing. What's going on in those 20 states that do offer the philosophical exemption. And, in fact, there is absolutely no correlation between a high non-vaccination rate, and the existence of a philosophical exemption.

In fact, West Virginia and Mississippi, two states that only have a medical waiver available to them, have amongst the lowest vaccination rates in the state. 68 and 73 percent respectively. The national average is about 77 percent. And I get those figures from a CDC produced report. I don't have it tonight because I wasn't prepared to talk about it, but I would be more than happy to furnish it to you.

In fact, a wonderful example is Minnesota. Minnesota has had the philosophical exemption for 31 years. Not only that, but they have full disclosure

laws, meaning anyone receiving a vaccine has to be fully educated as to the risks, potential for side-effects, as well as the VAERS system which is the mechanism for reporting adverse side-effects.

The specifics of the Minnesota full disclosure law is extraordinary. It's about three pages. With all of this, and 31 years of the philosophical exemption bill, Minnesota has, in fact, a higher than average national average rate of vaccination. 77.8 percent as opposed to the

national average of 77. These other figures I rattle off the top because they illustrate the point most extremely, but what I would love to do is provide to you a full-blown report, produced by the CDC of all the vaccination rates, and you can juxtapose it the states that have the philosophical exemption.

So my point is, Dr. Blad was incorrect. If you give people an easy way to "opt-out," it doesn't mean they're necessarily going to take advantage of that,

and if you offer them this, it doesn't mean there's going to be more disease and more death. To go from that point to the end of her sentence, it's just a stretch of reality that simply does not exist. But rather than hear it from me, I would like to provide you with the facts and the figures in the reports to show that point. Would you accept that?

CHAIRMAN GOTTFRIED: Absolutely. Certainly.

MS. PALMA: And, in closing, I would like to talk just briefly about the religious exemption, something that, yes, I

know you've heard many many times being talked about.

This is -- I filed religious waivers with my school district after being interrogated for four hours by a school district attorney, I was rejected both times.

The school district attorney was ultimately -- in one of the interviews, I taped him. I popped him on You Tube, 40,000

hits later, he was ultimately let go from the school district. So I'm sort inching towards my happy ending, at least with that side of the equation.

The religious exemption has to be strengthened as well, but I wanted to give particular emphasis to the medical waiver today because it was brought up in the context of the healthcare workers.

If an MD - if a currently licensed MD in the State of New York specifically states that this may harm a person accepting the vaccine, they -- you must make some sort of provision, some sort of specific provision in the law that states this must be followed. It cannot be denied, and it has to be accepted because the

reality is they are not. Thank you.

CHAIRMAN GOTTFRIED: Thank you. If I may say, if I were a school district, the idea of going against both and you Ginnie Fields, not a good idea. So, good luck, and keep us posted because anything that we can do to help with your situation,

I certainly want to do, and let me reiterate what I said early to one of the union representatives here. I believe the language in that regulation about medical contraindication means exactly what I said, and while I can't speak to what an individual employer might be able to do on its own, anyone who is rejecting a physician or nurse practitioner statement of medical contraindication, and citing this regulation is, to my mind, utterly off base and violating the regulation. If that is going on, I would like to know about it and will try to help.

MS. PALMA: Okay. You will assuredly know about it. I was given a deadline of the 25th to get a vaccine for my son or he would not be allowed into school the 29th. Now, I pushed back, and they said

they would allow him in school until a decision "was made."

The next piece of correspondence was, we are going to be reaching a decision October 7th. Here we are, almost a week later, and I still haven't gotten the decision.

I'm figuring I'm going to have the letter barring my son from school today. What can you do to help me? They are breaking the law. I cannot afford a lawyer. I'm sorry. I don't mean to make this all about me and my problem, but this has got to represent other things that are going on in the state that need to be addressed. Not just me and my son, but the healthcare workers, the medical waivers being completely trashed, and doctors being harassed and bullied. This is a problem that needs to be addressed.

Doctors don't want to write these things out even if they're legitimate because they could lose their practice, they could lose their income. They would put their families in jeopardy. This is the reality we're living with, how can you help us?

CHAIRMAN GOTTFRIED: Well, I was referring specifically to the healthcare

worker regulation. Although, I think I have always believed that the school mandate also would, as currently written, ought to protect the individual judgment of a health care -- of a physician, and I consider assembly 880, you know, basically gilding the lily, and it shouldn't be needed. It obviously seems to be.

One thing you might -- I would recommend is that, based on the testimony earlier today from the New York Civil Liberties Union, you may find a more welcome response from them than you might have in the past.

MS. PALMA: Yes, they have my paperwork.

CHAIRMAN GOTTFRIED: It does sound like their thinking has sharpened on the topic.

MS. PALMA: Yes, I have gotten them my paperwork. I think there plate is pretty full, but I'll keep at it, maybe I'll have Ginnie give them a call.

CHAIRMAN GOTTFRIED: The Civil

Liberties Union gets some of my money every month. They should be able to help you.

MS. PALMA: I would like to keep you apprised of my personal situation and get you the paperwork that I just described if that's okay.

CHAIRMAN GOTTFRIED: Okay. Thank you.

MS. PALMA: Thank you.

CHAIRMAN GOTTFRIED: Denise Webb, is she here? No. Okay.

Is Matt Conlon from Cantel Medical here?

(The witness was sworn.)

MR. CONLON: I am not here to talk about vaccines. And I'm really glad I don't represent a vaccine manufacturer right about now.

I'm not going to read my testimony. I hope to keep this very short and comment on a few things that we discussed here today.

Assemblyman Lancman, you made a comment earlier about the variety and the

number of different controls that can and should be implemented as a means to mitigate the effective -- any pandemic. And it does seem that the vaccine itself is being -- is overshadowing all those other mitigation techniques. Some of them obviously are pharmaceutical measures; others are non-pharmaceutical.

Another topic that was mentioned here was N95s versus face masks. My name is Matt Conlon and I'm with Cantel Medical. Cantel is one of the very few U.S. manufacturers of medical grade face masks, and they manufacture them here in Long Island.

Face masks are really being undervalued and overlooked in the whole scheme of things in this layered approach which the CDC recommends. If you think of each counter measure, whether it be medical or administrative, or otherwise, as a slice of Swiss cheese, no single counter measure, including vaccines, or antiviral medications, or hand washing, no single

counter measure is going to cover, you know, all of the required aspects of mitigating the spread of infection.

So face masks, we believe, are a very important component of mitigating the spread of infection and it's over -- face masks are overwhelmingly viewed as the little red headed stepchild to N95 respirators.

So I would like to clarify the difference between N95 respirators and face masks. Respirators are regulated under NYOSH, and OSHA recognizes respirators only as respiratory protection devices.

Face masks are not respiratory protection devices under OSHA, and are not cleared under NYOSH. Face masks are, however, very critical infection control devices that are regulated by the FDA, very tightly regulated by the FDA, and are critical infection control devices used in the hospital setting.

If any hospital were without face masks, surgical masks, virtually all

functions would grind to a halt within those settings. So they are a valued infection controlled device, and how is that? So why

are they dismissed next to respirators, it's because everybody's concentrating on respiratory protection of what will happen to me or what won't happen to me if I wear this device?

Face masks are designed, and the science is not refuted at all, very non-controversial to limit the source of infection. In other words, the wearer of that device has a much lower opportunity to spread the infection. So, if we just keep in mind by way of this picture here, this is the source of all contamination when we talk about flu viruses. It's from the mouth and the nose from sneezing or coughing or even talking.

Face masks are very effective in preventing that virus from being spread from the wearer of that mask. So all too often we skip that source control factor and we go right to what's going to prevent me from

getting sick from all of this that's in the air or on the surfaces, et cetera, without going right to the source?

So if I were the patient in the hospital, and I knew that I had a nurse that

didn't have a vaccine, and I'm making no judgment on that, but I would at least want that healthcare worker to be wearing a device that would protect me from her cough, sniffles, or sneezes, or what have you. It's just not viewed that way and it should be.

In fact, 40 percent of people infected with either the seasonal or the H1N1 flu virus are A symptomatic at any given time because there's a lot of time before the symptoms occur, and there's a lot of time after symptoms dissipate that the people are still infectious.

So if you're riding the subway in the morning, chances are, you don't know who is infectious and, whoever does sneeze or cough and makes your hair move as they do that, you're certainly not appreciative of

that, but I'd like to point out a scenario here.

If you had a choice of getting on one bus which -- but in order to get on that bus, you were given a respiratory protection device such as an N95 respirator, you got on that bus and nobody else is wearing a mask, and your other choice was getting on a bus

where everybody was wearing a simple surgical face mask, and you were not given protection to wear it, which bus would you choose to get on? My choice would be --

ASSEMBLYMAN LANCMAN: Bus one is you have a respirator and everybody else has nothing.

MR. CONLON: Yes.

ASSEMBLYMAN LANCMAN: Bus two is, everybody else has a mask but you have nothing?

MR. CONLON: Right. Which bus do you want to get on?

MR. LANCMAN: Well, I ask the questions here, mister.

MR. CONLON: Oh, sorry. Well,

hypothetically, my answer to that is that I would certainly want to get on the bus where everybody else is wearing the mask because it controls the source of that infection.

ASSEMBLYMAN LANCMAN: That's what I was going to say.

MR. CONLON: That infection coming from that person is mitigating the viruses that are landing on surfaces which can live for up to 24 hours, so once a day

cleaning of surfaces is pretty useless when there's a high traffic area. Within 30 seconds, that surface can be re-infected. That infection, again, travels from fingers to hands to buttons to computers.

So what I'm saying is, the source of the infection is being overlooked and the value of face masks which are, again, highly valued and critical infection control devices in the hospital setting, should be considered in a much broader context of not only healthcare workers but any setting, especially in New York City, where social distancing and three or six foot spacing is

simply not feasible.

And there should be no fear of wearing a face mask. It should be a courtesy from one person to another if they do have symptoms, the sniffles to wear a mask with no repercussions. In fact, the Asian culture wears masks for courtesy of others if they're symptomatic of anything at all. It's not a selfish use.

I think that that does it. There's a lot more in my written testimony. There's a lot science behind the value of face masks versus N95s. I certainly don't

discourage the use of N95s in high-risk settings, but there are certainly complications. One more thing, I'm sorry, I almost forgot. I do sit on a CDC committee which is trying to understand where the strategic national stock pile of critical devices are, including N95s and face masks.

They want to know when should they deploy these critical devices should the private sector not be able to get these anymore. I'm here to tell you that two

years ago I was invited to Washington by the Department of Health and Human Services, they presented me an entire presentation, they said we have a dilemma. We need 27 billion face masks in the event of a severe pandemic. They only had point 1 percent in a strategic national stockpile. This was two years ago.

Since that time, they have not been funded to add to that strategic national stock pile. So you need to keep in mind, whether it be N95s or face masks, that the recommendations that you may hear this week on their use or their lack of recommendation for their use, directly

reflect the fact that these are not contained in the strategic national stock pile, and have little bearing to the scientific evidence of their value. And that was admitted to me in a public forum by the CDC. So those recommendations are influenced by what's feasible in terms of availability.

That's all I have. Thank you for

your time tonight.

CHAIRMAN GOTTFRIED: Thank you very much and I think that added explanation was very helpful.

MR. CONLON: Thank you.

CHAIRMAN GOTTFRIED: Next is Josh Brown. Okay, he's not here. Diane Renna.

MS. GAVIN: I first want to say that my name is Elizabeth Gavin and I'm testifying on behalf of Diane Renna because she had to leave.

(The witness was sworn.)

MS. GAVIN: Hi. Good evening, gentlemen. Thank you for this opportunity to speak.

My name is Elizabeth Gavin and I am a registered nurse at the emergency department at Beth Israel Medical Center.

I'm going to share with you a quote from Barbara Lowe Fischer who is the cofounder and president of the National Vaccine Information Center, a mother of three children, a writer, and a speaker on vaccination and informed consent issues.

She states, the human right to informed consent to medical risk taking gives the citizen the power to make sure that the cure is not more dangerous than the disease itself. I agree. It is our responsibility as healthcare providers, concerned parents, mothers, daughters, fathers, brothers and sisters to stand up and speak out, and to assure that our human rights, specifically with regard to informed consent, are honored.

And this morning, as I left my house, I heard a quote on the radio on the way here and it was, in the face of injustice, silence is not a strategy. And in that spirit, I would like to testify on behalf of Diane Renna who is also a mother of three on the subject of religious freedom and the exemption of vaccination due to religious beliefs.

The following is her statement.

I am testifying today because I feel that certain freedoms are being seriously violated, religious freedoms.

Our country was founded on such freedoms and should not be taken for granted. In general, the morales in this country have gone sour and it is disturbing. Government and school officials should not dictate what they feel and think is a reasonable relationship between God and another person. For only God and that person truly know of this inner most personal love and trust, a faith and guidance so strong that it should not be reckoned with.

The mere fact that "in God we trust" was taken off of the front of the dollar coin is disturbing to me. Yes, I know it is inscribed on the side, but I'm sure Thomas Jefferson must be rolling over in the grave over this one.

God is a strong presence in the hearts of our founding fathers and religious freedoms were important to them. Our history is rich in the trust of God.

For the most part, I feel that

decisions people make for themselves and

their family based on religious beliefs, tenants, and spiritual guidance should not be dictated by government and school officials.

They should and are protected by law and the Constitution. The relationship between God and a person and the guidance they receive from God or spirit should not be influenced by government or anyone.

Today, I am focusing on the topic of religious waivers with regards to vaccination and attending school and also the H1N1 mandate. I have personally been affected by this and feel strongly about this subject. My daughter was required by law to get a Dtap booster for sixth grade.

Since we have sincerely held religious and spiritual beliefs and a close connection with God, Jesus, and the blessed mother, we chose to file a religious waiver for vaccination. We filled out the required paperwork. We went out of our way to extensively explain our tenants, beliefs and such, with two lengthy letters.

The principal and school board still felt that they needed to give us a "sincerity interview." The mere thought of a sincerity interview was very upsetting for us. You see, the reason why we became more spiritual and connected with God was because our daughter had a severe sensory processing disorder, also known as SPD.

To summarize, we went to hell and back. Our daughter is fine now and has since lost her diagnosis. The experience of looking back and rehashing our daughter's and family's journey was way too emotional. We chose to be proud of our family's accomplishments and feel blessed for them. We do not look back and squander in self-pity. We are thankful for our relationship with God, Jesus, the Blessed Mother. The richness and love our family has been blessed with is amazing. Because we did have a choice between medical exemption and religious exemption, we chose to hand in the medical exemption in replacement of our religious exemption. We

refused to be submitted to such a harsh and invasive and invasive attack upon our inner most relationship with God and our spiritual selves.

In closing, I would like to mention that it is our strong faith in God and his guidance that helped our daughter overcome her sensory processing disorder. Not only was I guided to best help our daughter, I also was guided to write a children's book to help other children entitled, Megan's World, the story of one girl's triumph over sensory processing disorder.

I am also guided to fight and advocate for children. I am here today because of my guidance from God. I will continue to follow my guidance and make a stand for him. No person should ever feel they are above him and no government should think that they can come between him and his people.

I am not afraid or intimidated to testify before you my beliefs and concerns

with regards to laws that try to corrupt the

relationship between God and human kind.

Thank you for your time and serious contemplation of the ramifications of withholding our Constitutional rights, and what our country was found on, religious freedoms for all. Sincerely, Diane Renna.

CHAIRMAN GOTTFRIED: Can you tell me what community or what school district was involved here? Can you repeat that?

MS. GAVIN: East Port South Manor.

CHAIRMAN GOTTFRIED: That's on Long Island. Thank you very much.

MS. GAVIN: Thank you. Arnold Gore, Consumers Health Freedom Coalition.

(The witness was sworn.)

MR. GORE: I'm Arnold Gore from the Consumers Health Freedom Coalition. Everything has been said, but not everyone has had a chance to say it. So I'll try to hit a few of the points I think were not covered.

In all of the discussion from all

of the doctors who are the generals in the war against the H1N1 virus, not one mention was made of the necessity to increase the amount of Vitamin D in the bodies of the

persons who are coming down with this disease.

There is now a huge amount of medical literature coming out showing that the reason why flu develops in the winter months in both the northern hemisphere when we have our winter, and in the southern hemisphere when they have their winter, is because there is a lack of sunlight and this sunlight provides vitamin D through the skin in the summer months, but is not -- the angle of the sun is not sufficient in the winter months and that's why vitamin D has to be supplemented. And if you supplement about 2000 international units of Vitamin D and Vitamin C, you will be able to enhance and build that immune system which has been completely overlooked by most of your so-called health authorities, and I really wonder whether they should be taken

seriously as health authorities.

I would also like to associate myself with the remarks of Dr. Michael Schachter and Gary Null, you were really beginning to hear some of the points which were absent in a lot of the earlier

discussion, which was boring as hell, and I don't know how you were able to stand it for two or three hours when they were repeating themselves about how they were going to wash their hands. It's really unbelievable.

How people can actually go to college to learn how to you wash your hands. And that's what we call a health authority.

There is another thing that was possibly not mentioned before. The Draconian Measures proposed by the Department of Health are not warranted by the real statistics behind H1N1 policy-mandating vaccines. You have made reference to the so called 36,000 deaths, and these on the Center for Disease Control website are actually the combination of the deaths from pneumonia, lumped with so-called

flu. When the monthly -- when the monthly mortality weekly report is consulted, you see that most of those deaths, something like 35,000 of them came from pneumonia, and maybe 100 to 300 were actually due to the flu.

And the Center for Disease Control comes back and says, well, you see, when people start out with the flu, they --

if they eventually die, they're probably going to develop something more serious, such as pneumonia, and then they take all the pneumonia deaths and say, well, that was due to flu. Everybody who developed pneumonia started out with the flu, which is not true. So the so-called 36,000 number that is bandied about nationally and probably about two or 3,000 in New York is due to that misinformation.

Other than that, I think I've covered everything that has not been mentioned before. So I'll end this quickly.

Thank you for the opportunity to for presenting this material.

CHAIRMAN GOTTFRIED: Thank you and thank you for the point about the flu numbers, we'll check that out.

Jake McHuge, okay, here's not here. David Foley? Joan Foley?

(The witness was sworn.)

MS. FOLEY: My name is Joan Foley and I would like to talk about freedom of choice. I am not a healthcare worker but I come to join in their battle. I had to fight in New York State Supreme Court to get

a religious exemption for my family so that my child could attend our school, and all because I made a choice not to vaccinate.

Because this choice did not coincide with the powers that be, I was grilled with hours of questions by my school district and then found to be insincere in my beliefs.

Even though the Constitution clearly states that a person's religious beliefs cannot be questioned, I was questioned and then forced to take this to Supreme Court because my school's lawyer

said I was not sincere and genuine. I won and my kids are in school. But, why was my freedom of choice trampled and ignored? Just because I feel differently than those in power, it doesn't mean the Constitution doesn't apply to me.

I believe that we humans are all on this earth to learn whatever lessons we came here to learn, and those lessons are different for each of us. Circumstances in my life will teach me my lessons, and circumstances in another's life will teach them theirs. We are all unique.

To say that I need to be like you

because you feel it is best for me is something you could not possibly know because you are not me. You don't know what I'm here to learn and, chances are, we are not here for the same reasons. I must make my own determinations and decisions based on what I feel is right for me. The government has no place in my personal decisions.

God gave us free will so that we could choose. You are free to choose

vaccines, and I am free to not choose them. I choose to trust in God. No manmade solution to disease can improve upon God's perfect immune system, and no manmade law override God's law of free will.

Our forefathers knew this when they wrote the Constitution. The First Amendment defends Freedom of Religion. It is the reason our country was founded in the first place. Back then, people were more in tune with their creator. They had a real sense of what was bestowed upon us by God. They made their laws accordingly. They wrote, In God We Trust, and felt good about it. They were guided by their hearts and their God.

Today, motives are tainted by greed and a lust for power. God's laws and those of our forefathers have been pushed aside for better "better laws and ideas."

Do you honestly think you can improve upon God's design? Do you honestly think that you should override God's gift of free will? At the Nuremberg Trials, it was

declared that no man can be injected without his consent. We knew back then that it was a violation of the worst kind. People were severely punished for having done this. Why don't we know that this is wrong now? Why do we keep having to fight for rights we are born with?

Forcing a person to get a vaccination against their will, and then threatening them with losing their job if they don't comply, is very unAmerican. I never thought that I would see the day when my country's leaders would behave this way. It is crossing a line that should not be crossed.

I am not saying that people should not take the vaccines. What I am saying is, all people are endowed with the inalienable right to make a choice as to

what goes into their bodies. This choice belongs to them and them alone, not the government. This mandate needs to be rescinded. Be leaders of good conscious and do what you know in your heart is right and

good.

CHAIRMAN GOTTFRIED: Can you tell me the school district involved in your case?

MS. FOLEY: Bayport Blue Point School District.

CHAIRMAN GOTTFRIED: At what level of court did you have to get to to win?

MS. FOLEY: I went to New York State Supreme Court.

CHAIRMAN GOTTFRIED: I assume, did you win at that level?

MS. FOLEY: Yes, I did.

CHAIRMAN GOTTFRIED: And the district did not appeal?

MS. FOLEY: They did not.

CHAIRMAN GOTTFRIED: Thank you. Next we have Lin Kriedemaker.

(The witness was sworn.)

MS. KRIEDEMAKER: My name is Lin

Kriedemaker. I'm here on behalf of myself and others. I'm in the medical profession. I'm a physical therapy assistant. I have

been for 18 years.

I'm writing and speaking on behalf of the medical profession and everyone who believes in freedom of choice, upon which America was founded and proud of.

Last year, Assembly Bill 10942, "The Worst Bill Ever," was presented to the Senate and Assembly. It was not passed. This year another approach was used to override the Senate and Assembly mandating that healthcare workers in hospital settings must have the swine flu and flu vaccine or they cannot work.

This was set forth by creating the illusion of a swine flu pandemic. According to what I have read, the swine flu is a milder form of the flu in comparison to the common flu. I have not, as many of us, have not seen a pandemic this year or last year. There is no emergency that can proven to exist to warrant any emergency regulation mandating the H1N1 vaccine or the common flu vaccine.

According to the news, people

that died from the swine flu had underlying conditions. There needs to be proof to which there is no sufficient evidence of a crisis except that we are told there is one.

The doctors have reported that there are less cases of H1N1 than the regular flu. This pandemic is pure speculation of how it could spread, the amount of people that could contract it, and a projection of possible deaths.

Speculation is not enough to warrant a medical emergency. This emergency was set by Mr. Daines who has allowed the use of a vaccine that has not been tested long enough for effectiveness or the possibility of injury to our bodies short or long term.

If these vaccines are so safe, why are their waivers of liability? We have become an experiment for a new vaccine. I am a healthcare worker for 18 years and I have never contracted the flu. I never had a flu shot. Our bodies do rise to the occasion creating natural antibodies

especially working with an ill population daily. It is against our Constitutional and human rights to force us to be injected against our will.

To add insult to injury, following the flu shot, we are to sign a waiver of liability by signing a statement in quotes, I understand the benefits and risks of the influenza vaccine. I request that the influenza vaccine be given to me."

This is so against our rights to not have the freedom of choice to opt-out of the flu shot and then being forced to sign that we requested it. Many healthcare professionals including doctors are against this mandate and vaccine. What type of people are in charge that would set forth such a regulation and blackmail us with the loss of our employment? I do not like to be blackmailed and I am speaking for the benefit of myself and the whole. We want to have the freedom of choice to say yes or no as to what enters our bodies.

As Gandhi once stated, where

there is injustice, I always believe in fighting. I hope after hearing testimonies all day, you feel there is enough information to see the injustice of a vaccine mandate and you will speak to Governor Paterson to do the right thing to lift this mandate.

I thank you for listening to this all day.

CHAIRMAN GOTTFRIED: Thank you. Eliana Hufnagel.

(The witness was sworn.)

MS. HUFNAGEL: Thank you very much for having us all here today. I know it's long and I know we're all tired, but I drove here quite early to be heard, so thank you.

I am requesting, of course, like so many other healthcare professionals, that you would consider taking action to reverse the mandatory vaccination of New York State healthcare workers for seasonal influenza and H1N1.

I am a register nurse for 17

years and I wish not to have either vaccine. I am currently experiencing autoimmune

issues and I feel that introducing something that could produce a very powerful immune response may jeopardize my health and any progress that I hope to make with my own health.

I would be willing to leave the profession I love so much to preserve my own health. Sadly, many healthcare professionals feel the very same way. I have never ever refused to care for a patient with flu or any other illness even while pregnant. Rather, I followed the rules of the facility that I worked in and done whatever PPE, which is personal protective equipment, that was necessary to protect myself, and the other patients I cared for, and the other staff I worked with from transmission of illness. Whenever I was sick, I would stay at home until well. I was a dialysis nurse for 14 years plus, and I would be often stuck in an MICU or CCU or SICU, isolation room completely garbed

from head to toe for four hours plus sweating over a patient with blood and needles, respiratory precautions, you name it, the worst case scenario. I never contracted it. I never passed it to

anybody. So this all seems very strange to me. Okay?

Something about all this does not feel right. I never put my patient's health in danger and would never do so. This mandate of all healthcare workers and the recommendation that everybody be vaccinated is plain dangerous. Everyone has an individual need and perhaps a problem that a vaccine could complicate. It is also a violation of our rights. We should be able to decide whether or not we want to take this into our bodies. There is no emergency.

My son and I had a case of H1N1 this spring, according to his pediatrician, who did not swab us, but rather prescribed Tamiflu and said stay home for five days. So I was pregnant at the time, had to take

the Tamiflu because my job said, you're better. I did that. I lost that fetus. I lost another one nine weeks ago. Something is not right. I have something going on, I need to look into it. My son whose six years old was vaccinated damaged between 15 and 18 months. He's under the care of Dr.

Boris who I think most people around here do know. He has MTHFR, as do I, and as does my nine year old, who has asthma.

This genetic mutation weakens my ability to clear my own body of toxins and heavy metals as do both of my children. It is not good medicine to force something that has mercury products like thimerosal and other adjuvants like aluminum and perhaps even squalene on me or my family.

I cannot sign an informed consent with bad information and inadequate data that is truly not informed consent. It is guesswork and a lot of finger crossing.

So my story is quite a bit like so many of these other people that have been here today, and I'll go on the record that I

concur with anybody who is opposed to this vaccine mandate for whatever their reason is.

Just in case you do not know, MTHFR is a pretty common, one out of -- with 30 percent of the population, maybe as high as 50 percent for Italians, I'm Italian, and what happens is the gene, the MRHFR gene has a mutation. The gene causes a weaker version of what is called methylene

tetro-hydro folate reductis, it is a protein involved with the folate in your body. I'm just giving you a real quick synopsis on it.

In any case, moving on, there is a Medscape video I saw because I am a nurse case manager for dialysis patients and people with kidney disease and so I must stay on top of things as I try to educate them.

So there was a doctor and his name was Paul G. Olwader. He was a Medscape infectious disease site advisor and this was distributed to many people. In this video, he feels it incumbent for me take this

vaccine. He doesn't know me. He doesn't know what I've been through. He doesn't know what's happening in my body. I say not so fast. He actually says in the video at the end, I hope it is safe. How dare he.

Please consider this scenario. How will hospitals, offices, and clinics be able to provide care to those who do need care if we are all terminated because we will not take the vaccine? Has anyone -- Mr. Daines considered this? And if the vaccine is harmful, the government would

have wiped out the majority of healthcare workers, so then who will be around to provide healthcare?

With fewer experienced healthcare professionals at the bedside and in the clinics, we then will see the real emergency. And just because I have it written right here, there was a fellow here earlier, he was a doctor from a clinic and he was concerned about RNs not being able to get the flu vaccine out, and he wanted an LPN to do it. Not only is it outside the

scope of an LPN to go on and just go ahead and give them, an LPN in the State of New York is not allowed to assess a patient, and when you give a vaccine, you must be able to assess a patient for a reaction post administration. So please don't listen to him. He doesn't know what he's talking about.

Another major concern is about giving live virus to healthcare workers. The virus may be shed from these vaccinated workers as they care for our sickest people in the hospital, thus transmitting it anyhow. What is the rationale for this? Where are the infectious disease experts on

this? Some have spoken out and then we stopped from them, like on Fox news and on Channel 12 last month. More of these concerned doctors need to speak up as well rather than telling us secretly and hiding in fear.

I'm hoping this committee will listen to our concerns without worrying about what reversing the decision might do.

It surely would be the right decision to do -- it would surely be the right decision to at least halt the mandate. There's nothing at stake here accept rushing into something and making a big mistake.

I also want to mention, I know there was some mention on mercury. It was a recurring thing here today, and while we were here today at 10:30 this morning, up in Albany, there was a -- they were having a public hearing. The subject was mercury exposure, and they were examining measures to reduce mercury exposure. And they do, you know, our own assembly people up in Albany, mercury natural occurring, concerns that studies have found, mercury exposure at high levels can harm the human brain, heart,

kidneys, immune system, infants and children are especially susceptible. At high levels of exposure, mercury, death, reduced reproduction, abnormal behavior, and slower growth in develop of fish. And so, yeah, they're biological to. They can test a rat. They can test a fish.

I also included in the packet I gave to you which looks like this (indicating), the highlights of the prescribing information from the flu mist which does not have the preservative, but even without the preservative, it's pretty disturbing that in here, they actually say, and it's all -- I went ahead and highlighted it for you so you can find it easily, the data supporting the safety and effectiveness of just flu mist, and they're assuming that flu mist, since the H1N1 nasal is made the same way, that this insert counts for both, even though they haven't studied the H1N1 nasal. They're just saying, we didn't study that, but we're going to assume it's the same because we made it the same way.

The data supporting the safety and effectiveness of flu mist administration in immuno-compromised individuals are

limited. It should not be administered unless the potential benefit outweighs the potential risk. It may not protect all individuals receiving the vaccine.

And then here, there was something -- there was a question earlier about -- the clinical trials adverse reactions when you want to compare how a vaccine is made now in a similar fashion to one before. It says here, because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice. And these drugs are labeled differently. They're different drugs. They have a different label. They're called something different. They have a different virus. So I will answer that question that needed to get answered. Okay.

If you look through this packet, you will see some of the study data just like Dr. Null and others have said. It is so poorly conducted. They stopped looking

at some of these kids that they tested after 10 days and said, oh, had enough, not

looking anymore. Amazing.

Following adverse reactions were identified during post approval mist of flu mist, and because these reactions were reported voluntarily from a population of an uncertain size, it's not always possible to reliably estimate their frequency or establish a causal relationship.

Well, gee, if I was a manufacturer of a vaccine and had people calling in after the fact, I'd want to look at those people and, you know, who to look at because they just called you. It is incumbent that the CDC and the manufacturers deeply look into the possibility of a causal relationship. Congenital famille genetic disorders, GI disorders, immune system disorders, nervous system, Guillian-Barre, Bells Palsy, and it goes on and on. Drug interactions. I wish they were here, you know. They only give you part of the story. Our doctors just go ahead with it. I don't understand. Where is the scientist and the doctor. They have take science,

biochemistry. I don't get it. They forgot that part.

The safety and immunogenicity of this vaccine has not been determined when it's given with other vaccines. Studies of flu mist excluded the subjects who received any inactivated subunit vaccine within two weeks of enrollment in the study.

Therefore, healthcare providers should consider the risks and benefits of concurrent administration of the influenza H1N1 monovalent live in the nose vaccine with any inactivated vaccine. It doesn't even say in here how long to wait.

The safety has not been established. It says here adverse events were similar to those seen in clinical trials with flu mist. Similar. They don't really know. Here you go, the pregnancy stuff, this is very serious. Pregnancy category C, A, not a big deal, B probably nothing, C, starts to show something. They know something. They're saying that they don't know, then don't call it a category C.

That's contraindicating themselves. Animal reproduction studies have not been conducted with this vaccine.

It is not known whether this vaccine, the live flu mist, can cause fetal harm when administered to a pregnant woman, or if it can affect reproduction capacity. It should be given to a pregnant woman only if clearly needed. Well, I don't see an emergency. Nobody in my school district died from H1N1, and it was there. This is this is negligent. And now they have cart blanche to do what they want because they've been excused from any kind of liability, which raises anybody with one brain cell, it will raise suspicion, why are they exempt? That makes -- there's no reason for that unless there was something to hide.

Why would you give a healthcare worker something that might shed when the very reason you're telling them they have to take it is to protect the patients? Well, if I'm standing over a patient and I happened to have had it, I may shed on them.

That doesn't make any sense to me either.

Again, two different messages coming out here. I'm scared. I'm scared.

Neither influenza H1N1 vaccine monovalent or the flu mist have been evaluated for carcinogenic or muted genic potential or potential to impair fertility. This is a recurrent thing. This is just the highlight. They modified their study information. And another thing, I'm not even going to read that to you. It goes on and on. There's just two more little things here and then I'll be out of your way.

Like Dr. Null said, the proper type of study to be done is randomized, double-blind, placebo controlled trials. A lot of what's in here is not that kind of data. Please look at that and understand that. Okay?

Why is nothing else studied in that fashion but just certain little bits and pieces with the HIV patients. They happen to have -- I don't know, a fairly decent number of them, you know, 54 and 57

patients.

The transmission study is very troubling. It says here, this does contain

live attenuated influenza vaccine that must infect and replicate the cells in the lining of the nasal pharynx. So it sets up in there, stays for three to five days. That's when you start to get immunity. It replicates in there then it triggers your immune response.

The relationship of a viral replication in a vaccine recipient and transmission of vaccine viruses to other individuals has not been established. It should have been established before they started giving it to the nurses and the staff in the hospital who are probably right now maybe standing over the bed of someone whose immunocompromised on chemo.

Type A influenza virus was documented to have circulated in community and in another study population during the trial. But then that's not a controlled study either. The duration of a flu mist

vaccine virus replication in the shedding has not been established. Again, I don't get it.

Vaccine recipients and their parents and guardians should be informed by their healthcare provider that this live

virus vaccine has the potential for transmission to immunocompromised household contacts.

Well, I could tell you that when I worked in the hospital, I spent most of my waking day where I was upright, probably more likely to shed during the day in a hospital, not around my household contacts. I might go home, make my kids dinner and put them to bed. So why are they telling us that we have to be concerned about going home and transmitting it to an immunocompromised household contact? It's right here. But we're allowed to march into the hospital and work. But they're saying you can't be a vector. They're thinking we can be a vector. They just made us vectors. This is negligent. This has to be looked

at. This scares me. What's really going on here needs to uncovered. I've terrified.

I'll say one more thing. I can't take the vaccine, I have a medical exemption. I'm good to go. My children don't. I have one who is going to go to middle school soon. He has MTHFR. He had the whooping cough even though he was fully

vaccinated, they're going to want to give him that again. Why? He wasn't immune the first time. Think about this. Think about your own children, if you have grandchildren. This sets precedent. What's going to come later? We are a poisoned society.

Another thing you need to look at is -- in my generation, there is a tremendous amount of infertility. This is a brand new business.

This next generation that came off of us that are infertile are the autistic generation. If somebody doesn't do something, it's only going to get worse. And then whose going to support them? I

need to stay healthy. I need to stay alive so I can make sure that my kids are taken care of for as long as I can, because I know the government isn't looking at them. I hope that you would. Thank you.

CHAIRMAN GOTTFRIED: Thank you. Yekaterina Sorokina.

(The witness was sworn.)

MS. SOROKINA: I really appreciate that you're letting everybody speak. I'm really going to bring this down

to size, take out a lot of stuff and just concentrate on various points.

Something that the previous speaker brought up, I think it Ms. Hufnagel, about the flu mist for the healthcare workers. It's definitely very alarming, but it's also very alarming in the community because this vaccination is being used in crowded places like the mall and we have immunocompromised people in the community, not just in the hospital; people who have HIV, AIDS, who are on chemotherapy are in the community as well.

The CDC, if you look at their site, they say that people after the flu mist vaccine are from point 5 percent to 2.5 percent infectious. That means like out of 100 people that we are vaccinating with the flu mist, two of them in the mall walking around are infectious, they could infect other people, especially those immunocompromised patients that we're worried about because now they're in the community, they're not patients, but they can still, you know, get the flu.

Another thing I wanted to talk

about. By the way, I'm an RN. I work at an HHC facility in Brooklyn. They are totally violating the regulation. I was given a piece of paper with my options for exemptions. It specifically says that only two boxes could be checked. There's like no other options. So I have to have had anaphylactic reaction to a previous flu vaccine or anaphylactic reaction to eggs. That's like pretty serious. You know, that's like you almost die. So anything

like, shortness of breath or rash, that's not good enough. It has to be anaphylactic reaction, but I also think that --

ASSEMBLYMAN LANCMAN: One second, if I may. So you work at an HHC facility?

MS. SOROKINA: Yes.

ASSEMBLYMAN LANCMAN: Which one?

MS. SOROKINA: Wood Hall.

ASSEMBLYMAN LANCMAN: And they gave you a form which had -- for the medical exemption part only two options?

MS. SOROKINA: It was either two or three options, but all of them were preceded with anaphylaxis.

ASSEMBLYMAN LANCMAN: And do you have a different medical exemption?

MS. SOROKINA: I would like -- no, I don't have a medical exemption. Not that I know of. I am very highly allergic to many substances and I have arthritis already at this age.

ASSEMBLYMAN LANCMAN: I'm just curious, was one of the boxes other, and then you had an opportunity to go to your

physician?

MS. SOROKINA: No. No. No.

ASSEMBLYMAN LANCMAN: Do you have a copy of that?

MS. SOROKINA: I can provide you. How?

ASSEMBLYMAN LANCMAN: When you're done, I'll give you my card and you can e-mail it to me or fax it.

MS. SOROKINA: But I also think that people should be exempt not just on medical reasons, but on philosophical reasons as well. I think a lot of people have touched up on, you know, the safety issues and that people are mistrustful of the FDA because of so many, you know, drugs that have been approved that had to be recalled. You know, you've heard those

statistics.

Also, something like the influenza vaccine, well, I'm actually going to use the CDC's own numbers to demonstrate that it's not particularly effective, hence, we shouldn't be forced to get this. There's

other means. So this is as per CDC. This is their statistics.

It says that during the season when the viral strains have been matched up properly with the virulent strains, and it's administered to patient -- I mean, people who are younger than 65 years old, and don't have any chronic conditions so they would have to be, like, middle to young adult, and not have any chronic conditions like obesity, hypertension, diabetes, that's like a lot of people who have that. So you're basically ruling out all of that, it has to be like a young to middle adult who is completely healthy and everything had to be matched up right. So considering all that, the effectiveness is 70 to 90 percent. So 90 is like an ideal case scenario, I don't know how often things in the real world ideal, so this is like for really healthy people. So let's say 70 percent as per CDC,

but then you also have, for instance, nurses who are obese, who have hypertension, who have like chronic disorders. So it's not

going to be 70 percent effective for them.

So as per CDC, you know, if you go and look at their statistics, if you're older than 65 or have a chronic condition, it's only like 50 percent effective. So that's some nurses who will get the vaccine and think they're protected and go and interact with immunocompromised patients and will, in fact, make those patients sick because they could very possibly contract influenza.

Let's see, also, if it is effective, the influenza vaccine for those individuals for whom it's effective, there still could be viral shedding, because it's not, like, you're immune, like, oh, my God, your body is not going to accept this virus. It still will go into your body if you're interacting with someone who has the flu and you've been vaccinated and it's effective, it will still go into your body, and will still trigger an immune response. What that means, is that you have to had been

infected. That's how it works because you

have the immunoglobulins which take care of the virus, but the thing is, you have to contract it. So you may still be shedding virus, so even for those healthcare professionals who get immunized and for whom it's effective, they could still be shedding, so they're protected. They're not going to get the severe symptoms, but, you know, the person they're taking care of may.

So, you know, that's another reason why this cannot be, you know, you can't force people to do this and it's so ineffective. I mean, I'm not against vaccinations and I'm certainly not against influenza vaccinations, but you can't force people to accept something into their body that is questionable. There is evidence it is questionable, safety. You can review that from the other speakers.

It's not particularly effective as I just described, and this is using CDC statistics. This isn't some random, you know, something you're not familiar with. It's something you're very familiar with.

What else did I want to mention? You know, as far as influenza being, you know, a nosocomial infection, well, yes, it is on the list, the CDC's list of nosocomial infections, that's hospital acquired infections, but there is really no proof that it's the health are personnel that transmit this. There are certain things that definitely the healthcare personnel has a lot responsibility in, and should definitely be looked into as far as nosocomial infections such as intravascular catheter related bloodstream infections, urinary catheter associated UTI's, ventilated assisted pneumonia, surgical site infections, those account for 60 percent of nosocomial infections. So then the other 40 percent of nosocomial infections, influenza shares with over a dozen other infections, so forcing employees to get vaccinated against something like -- that's in the minority of hospital-associated infections, especially if it doesn't work that well, especially when immunocompromised patients

would be very well served by employees, you know, using reverse isolation techniques. Because I have seen in hospitals that -- and somebody would be in reverse isolation because their white blood cells are in the gutter and, you know, visitor doctors come into the room without a mask. That is not appropriate. You know, reverse isolation should be strictly enforced. Those that we're trying to protect, the immunocompromised patients would be very well served because, besides influenza, there is a slew of other conditions that they're susceptible too. So that was another thing.

If you go to the Joint Commission on Accreditation, I mean, I'm sure you've heard of them, they have lined out 28 guidelines for suggesting how to increase immunization in healthcare facilities. None of those guidelines include forced vaccinations. You know, you provide data, you talk to people and find out what their concerns are. And you have to -- as per the

joint commission, it would be a very good idea to have opt-out waiver for those who

want to opt-out for whatever reason they want to opt-out, but the thing is, now you have to make a choice. If you feel strongly enough that you have to opt-out, then you have to fill out a waiver. It's not going to be disputed, it's your reasons.

But then, a lot of people, they're ambivalent about it, so they're like, all right, well, you know, I either get the vaccine or I fill out this waiver, well, I don't really have any firm beliefs so I'll get the vaccine. Done. So some hospitals had a success rate of 80 percent vaccination. Not forced. Not mandatory. So, you know, that data is on the Joint Commission site.

Also, I would like to say that patients have a big responsibility in infection control that they don't recognize. I've had so many patients who refuse to wear the mask. I have done teaching --

CHAIRMAN GOTTFRIED: I'm sorry,

we asked witnesses at this hour to keep their testimony to five minutes.

MS. SOROKINA: I'm sorry. I did intend to do that.

CHAIRMAN GOTTFRIED: If you could wrap up.

MS. SOROKINA: But basically I think that a mass education campaign should be done in regards to the public being aware that they have a big responsibility such as, you know, staying at home if you have flu like symptoms. If you have flu-like symptoms and you come to your doctor or the ER, wear the mask. Don't not wear the mask, especially when we're asking you to wear the mask.

I am done.

CHAIRMAN GOTTFRIED: Thank you very much. Next is Eduardo Fontana.

(The witness was sworn.)

MR. FONTANA: This is my first time testifying, and I've waited about 12 hours. I'm just curious, did New York State Assembly members and supporting staff,

including the stenographer, you guys took a booster for breakfast this morning, because I want to commend you on understanding and your ability to listen to our conditions. I really want to applaud you for that.

CHAIRMAN GOTTFRIED: Thank you.

MR. FONTANA: It is rather

gratifying to see that. Now, I feel compelled to clarify three points that were touched upon earlier, so I simply want to briefly review them.

Point number one, how many people really get the flu? Most people suffering from fever, fatigue, cough, and aching muscles think they have the flu. They do not. Instead, they have an influenza-like illness, or ILI, associated with many different germs. So just rhino viruses, respiratory viruses, or RSV, influenza viruses, Legionaires, SAP, climidias pneumonia, micro-plasma pneumonia, and streptococcus pneumonia, but the not the flu virus.

Now, in addition, there was some

hint at the following figures that, "how many people die from the flu?" You may have heard that the flu kills over 30,000 Americans every year. That is simply not true. Lump flu and pneumonia death together, but flu death have only a small fraction of the total.

For example, in 2002, when the flu plus pneumonia death were reported at

over 60,000, only 753 were flu deaths.

In 2001, the total number of flu deaths was 267. Does this justify giving a poorly tested and dangerous vaccine to millions of people? I believe not.

In my presentation to you, you will see a picture of Cody Mainsern left at length two comments of the advisory committee and immunization practices make recommendations on Wednesday. This is from the Wall Street Journal on July 30, 2009.

In it, I'm just going to briefly point to the fact that pregnant women are of a particular concern to public health officials. They happen to be a great

concern to me because I represent perhaps the voice of the voiceless. That is the generation Y2K. That is my children, your children, my grandchildren, your grandchildren, my nieces, your nieces, and they are being exposed to so many toxins that we have no control what's going to happen to them by the time they reach puberty.

Therefore, I would like to present to you that in view of the limited time, you will see that I included a package

insert. It's confidential proprietary information on the use of specific population, so just in pregnancy, pregnancy category C, animal reproducing studies have not been conducted with influenza A, H1N1 2009, monovalent vaccine.

It is also not known whether these vaccines can cause fetal when administered to a pregnant women or can affect reproduction capacity influenza, H1N1 2009 monovalent vaccine should be given to a pregnant woman only if clearly needed.

And you got the same thing for nursing mothers, you have -- it is not known whether influenza A is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when this vaccine is administered to a nursing woman.

CHAIRMAN GOTTFRIED: Excuse me, I apologize for interrupting, but several witnesses have read us that material today.

MR. FONTANA: Yes, Assemblyman Lancman asked for that insert. So I just wanted to make sure that you have that insert right now in front of you, and I just

wanted to allude to that.

In addition to the two points that I made earlier, there's a third point I want to emphasize that has not been pointed out, and, that is, that they submit that acute illness is bad for us.

The fact of the matter is that traditional healers have recognized the benefits of acute infections of illnesses. Hippocrates, the father of medicine wrote,

disease are prizes of purification of toxic elimination. Symptoms are the natural defenses of a virus. We call them diseases, but in fact they are the acute diseases.

The cleansing of detoxifying in illnesses such as the flu, fever, vomiting, diarrhea, sweating, are uncomfortable and yet are of great benefit.

When properly managed, acute infection illnesses, leave a stronger, cleaner, healthier person in its wake. Researchers have discovered that those who have had febrile infection childhood diseases have less cancer as adults, and you'll see the differences in medical literature here. This is from the febrile infections in childhood disease in the

history of cancer patients, and much contra-medical hypotheses.

So I just wanted to point out that we have that third scenario. In addition to the package insert, I want to add that according to the literature that I have in front of me, the swine flu shot

contains untested dangerous chemicals.

The new H1N1 swine flu vaccine will be made in PERC six cells, which is human retina cells, and contain MS-59, a potentially debilitating oil-based adjuvant primarily composed of squalene. Between 80 and span 85, all oil adjuvants injected into rats were found to be toxic. In testing all rats development on MS-like disease, left them crippled and dragging their paralyzed quarters across their cages. When injected in humans at 10 to 20 PPB, severe immune responses, such as arthritis and lupus were reported according to the expert review of vaccines, monovalent vaccines, the killing of soldiers and the GIs are the only first victims of this vaccine.

In addition, squalene is linked to autoimmune diseases including rheumatoid

arthritis, multiple sclerosis, lupus, Lou Gehrig's Disease, and Gulf War Syndrome. Research revealed that all GWS patients immunized for service in the Desert Shield Desert Storm had no antibodies to squalene.

So I just want to share, in view of the limited time, and I don't want to abuse the privilege that you have given us, that a lot of what the CDC is not revealing for obvious reasons, and I am very concerned about our mothers in our next generation.

We have a very serious health matter in our hands. I feel compelled to please think this very carefully. You know, in the words of one of my country's founders, he said the following almost 200 years ago, "never has it been so necessary like today to have health, heart, and to exercise good judgment." Today, that man with that judgment and without heart conspired against the health of the union. The same applies today. Please reconsider mandatory vaccination. Thank you very much.

CHAIRMAN GOTTFRIED: Thank you. Jenny Winship? No. Paul Kowalski? No. Robert Lutz? No.

I think that completes the list

of folks who have signed up to testify. So I'm going to adjourn this hearing. I thank

all of you who came here today to testify. I thank my colleague, Rory Lancman, for sticking it out so long with me, and, as always, I thank our stenographer who is always the hardest working person in the room at these hearings. So we will now adjourn the hearing. Thank you.

(Whereupon, the committee hearings adjourned at 10:10 P.M.)

C E R T I F I C A T E

I, EDWARD LETO, a Shorthand Reporter and Notary Public in and for the State of New York, do hereby stated:

THAT I attended at the time and place above mentioned and took stenographic record of the proceedings in the above-entitled matter;

THAT the foregoing transcript is a true and accurate transcript of the same and the whole thereof, according to the best of my ability and belief.

IN WITNESS WHEREOF, I have hereunto set my hand this _____ day of _____, 2009.

_____

EDWARD LETO